



September 2009

Dear software developer,

A revised, updated copy of the *BCBSM EDI Professional 837/835 Companion Document* is now online at [bcbsm.com/pdf/systems\\_resources\\_prof\\_837\\_835.pdf](http://bcbsm.com/pdf/systems_resources_prof_837_835.pdf).

The table below summarizes the changes to 837 and 835 transactions

Section	Description of Change	Page
<b>ANSI ASC X12N Professional 837 (004010X098A1) – Reporting Instructions Clarifications</b>		
General Overview	Revised 3 <sup>rd</sup> paragraph	4
Coordination of Benefits	Revised 1 <sup>st</sup> paragraph, last sentence	7
Loop 2000B, segment SBR09	Revised	8
Submission of BCBSM/BCN Status Inquiry Claims	Revised last sentence	9
Professional 837 and 835 Interchange Envelope and Functional Group Structure - Transaction Set Professional 835 Health Care Claim payment Advice, Element GS08	Revised Instruction	15
<b>Data Clarifications for the Professional 837 (004010X098A1) Transaction Set</b>		
Loop 2000A, All	Revised last paragraph	16
Loop 2000A, PRV01, PRV02, PRV03	Revised last paragraph	16
Loop 2010AA, NM108, NM109	Revised Instruction - Commercial	17
Loop 2000B, SBR02	Revised Instruction – Medicare, Medicare Advantage etc	18
Loop 2000B, SBR09	Revised Instruction	18
Loop 2010BA, NM102	Revised Instruction	19
Loop 2010BA, NM109 Qualifier MI	Revised Instruction	19
Loop 2010BB, NM109, Qualifier PI	Revised Instruction	20
Loop 2000C, All	Revised Instruction	20
Loop 2300, CLM05-3	Revised Instruction	21
Loop 2300, CLM06	Revised Instruction	21
Loop 2300, DTP03 Qualifier 439	Revised Instruction	22

Section	Description of Change	Page
Loop 2300, PWK and NTE	Revised Instruction	22
Loop 2300, REF02, Qualifier F8	Revised Instruction	23
Loop 2300, HI Segment Diagnosis Code	Revised Instruction	24
Loop 2310A, NM108, NM109	Revised Instruction	24
Loop 2310D, NM103	Revised Instruction	25
Loop 2320, CAS	Revised Instruction	26
Loop 2320, AMT02 Qualifier D	Revised Instruction	26
Loop 2320, AMT02 Qualifier AAE	Revised Instruction	26
Loop 2330A, NM103-NM105	Revised Instruction	27
Loop 2330A, NM109 Qualifier MI	Revised Instruction	27
Loop 2330B, NM103	Revised Instruction	27
Loop 2400, SV101-1, SV101-2	Revised Instruction	28
Loop 2420A, REF01, REF02	Deleted – was on page 31	
Loop 2420C, NM103	Revised Instruction	31
Loop 2430, SVD01	Revised Instruction	32
Loop 2440, LQ	Added	32
Loop 2440, FRM	Added	32

If you have any questions regarding this information, please call our EDI Help desk at 800-542-0945.

Sincerely,



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**Blue Cross Blue Shield of Michigan HIPAA EDI Companion Document**  
American National Standards Institute (ANSI) ASC X12N837 (004010X098A1) Professional  
Health Care Claim and 835 (004010X092A1) Health Care Claim Payment/Advice

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## **Table of Contents**

<b>Table of Contents.....</b>	<b>1</b>
<b>Introduction .....</b>	<b>3</b>
<b>ANSI ASC X12N Professional 837 (004010X098A1) – Reporting Instruction Clarifications.....</b>	<b>4</b>
General Overview.....	4
Hierarchical Structure.....	4
Maximums/Limitations .....	5
Claim Reporting Clarifications.....	5
Type of Service.....	5
Character Set Requirement.....	5
Provider Identification Numbers .....	6
National Identifiers .....	6
National Provider Identifier (NPI).....	6
Claim Editing.....	6
Coordination of Benefits .....	7
Submission of BCBSM/BCN Status Inquiry Claims.....	9
Reporting Commercial Payer IDs and Claim Office Numbers.....	10
Professional Electronic Claim Exclusions .....	10
EDI Clearinghouse Exclusions .....	10
<b>ANSI ASC X12N Professional 835 (004010X091A1) – Remittance Clarifications .....</b>	<b>10</b>
835 Balancing.....	11
Maximums/Limitations .....	11
Provider Identification Numbers .....	11
Payee Identification .....	12
Control/Reference Numbers .....	12
Claim and Service Level Information.....	12
Bundling and Unbundling.....	12
Claim/Service Adjustments .....	12
Claim Interest and Prompt Payment Discounts .....	13
Reversals and Corrections .....	13
Claim Splitting by Payers .....	13
Blue Exchange.....	13
<b>Additional Information .....</b>	<b>13</b>
TA1 Interchange Acknowledgements .....	13
997 Functional Acknowledgements.....	13
Unsolicited Claim Status (277).....	14

**Professional 837 and 835 Interchange Envelope and Functional Group Structure..... 14**  
**Data Clarifications for the Professional 837 (004010X098A1) Transaction Set..... 15**  
**Data Clarifications for the Professional 835 (004010X098A1) Transaction Set..... 33**  
**General EDI Terminology ..... 36**

## **Introduction**

This document is the property of Blue Cross Blue Shield of Michigan and is for use solely in your capacity as a trading partner exchanging health care transactions with BCBSM.

This document provides information related to specific elements within the addenda version of the ANSI ASC X12N 837 transaction, but does not change the definition, data condition, or use of a data element or segment in a standard; add data elements or segments to the maximum defined data set; use any code or data elements that are either marked “not used” in the standard’s implementation specification or are not in the standard’s implementation specification(s); or change the meaning or intent of the HIPAA standards implementation specifications.

This document is intended for use as a companion to the HIPAA-mandated ANSI ASC X12N Professional 837 and 835 transaction set Addenda Implementation Guides. Specific payer instructions contained in this document are provided for clarification purposes only and should be used in conjunction with the applicable HIPAA Implementation Guides published by Washington Publishing Company, companion documents, EDI User Guide, physician’s manuals, and/or other billing guidelines published by our clearinghouse payers, including BCBSM. Implementation Guides can be purchased from the Washington Publishing Company web site at [www.wpc-edi.com](http://www.wpc-edi.com). Copyright (c) 2000, Data Interchange Standards Association on behalf of ASC X12.Format (c) 2000, Washington Publishing Company. All Rights Reserved.

This document is incorporated by reference in the EDI Trading Partner Agreement. All instructions were written as known at the time of publication and are subject to change. Changes will be communicated in future letters and on the BCBSM web site: [www.bcbsm.com](http://www.bcbsm.com).

Appropriate steps must be taken before submitting production Addenda ANSI ASC X12N transactions, such as testing, completion of an EDI Trading Partner Agreement and demographic confirmation with our customer support staff. To begin this process, receive more information or ask questions, please call the EDI Help Desk at 800-542-0945.

## **ANSI ASC X12N Professional 837 (004010X098A1) – Reporting Instruction Clarifications**

### **General Overview**

The Health Insurance Portability and Accountability Act requires that all health insurance payers in the United States comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The addenda version of the ANSI ASC X12 837 transaction set has been selected as the format to meet HIPAA requirements for the electronic submission of professional health care claims. The BCBSM EDI clearinghouse accepts ANSI ASC X12N 837 addenda version professional transactions for BCBSM, Medicare Advantage/Medicare Plus Blue (including DME), BCN, BCN Advantage, Blue Card, FEP, Medicare B, MDCH (Medicaid) and commercial carriers. For commercial claims, the destination payer must be the primary payer. BCBSM vision and hearing claims can also be submitted within the 837 transaction. Acceptance of 837 and return of 835 transactions will occur in batch mode and will not be accommodated in the real-time environment.

- BCBSM EDI may edit data submitted beyond the requirements defined in the HIPAA Implementation Guide.
- BCBSM EDI may reject interchanges, functional groups or transactions that do not follow all HIPAA Implementation Guide and BCBSM Companion Document requirements.
- BCBSM EDI will reject an interchange that is submitted with a submitter identification number that is not authorized for electronic submission.
- BCBSM EDI will reject a file that is determined to be a duplicate of a previously submitted file.

Trading partners should note that if the information associated with any of the claims in the 837 ST-SE batch is not correctly formatted from a syntactical perspective; all claims between the ST-SE would be rejected. Providers should consider this possible response when determining the size of their transactions.

Medicare Advantage/Medicare Plus Blue (including DME), is a coverage that combines an insured's Medicare and BCBSM Supplemental benefits. Claims for Medicare Advantage/Medicare Plus Blue must be submitted as Medicare claims with the following exceptions:

- The Payer Identification Number, reported in NM109 of Loop 2010BB, must be equal to 00710.
- The Insured's Primary Identification Number, reported in NM109 of Loop 2010BA, must contain the BCBSM assigned contract number for the insured. It is recommended that the alpha prefix, followed by 9 numeric characters, be reported on all Medicare Advantage/Medicare Plus Blue claims (including DME).
- Claims submitted without the appropriate billing and rendering provider NPI may be rejected.

BCN Advantage is a coverage which combines an insured's Medicare and BCN Supplemental benefits. Claims for BCN Advantage, should follow BCN reporting guidelines for Claim Filing Indicator, Payer ID, Provider NPI and Member's contract number. All other claim/service related information should follow Medicare billing instructions. Refer to Segment/Element reporting instructions for further detail.

### **Hierarchical Structure**

The 837 format incorporates a hierarchical structure to make the submission of health care claims as efficient as possible. A hierarchical structure identifies relationships between the provider, subscriber, and patient and can eliminate repetitious reporting of data.

One example of this is the ability to report claims for both the subscriber and dependents without repeating the subscriber information.

A subordinate dependent hierarchical level should not be included when the subscriber is also the patient and no additional claims are being sent for the subscriber's dependents. Additional patient information should be reported at the dependent level when the dependent is the patient or when there is a combination of claims for the subscriber and their dependents. Address and demographic segments are only required for the patient/dependent when dependent claims are submitted for a subscriber.

The dependent hierarchical level should only be used when there are claims for dependents or claims for both the subscriber and dependents. To ensure correct processing of Blue Care Network HMO claims, it is important to report the correct loops and relationship code of the patient to the insured.

### **Maximums/Limitations**

- Report up to 100 claims per subscriber/patient combination.
- Submit a maximum of 5,000 claims per transaction set.
- Up to 10 other carriers can be identified in addition to the destination payer, however, individual payers may not reference all reported occurrences.
- Decimal data reported in data element 782 (Monetary Amount) is limited to a maximum length of 10 characters including reported or implied place for cents (implied value of 00 after the decimal point). Note: the decimal point and leading sign, if sent, are not part of the character count.

### **Claim Reporting Clarifications**

- When reporting dollar amounts of zero, report that amount (do not leave blank) in the transaction. If required amount elements are left blank, the claim will be rejected. When reporting percentages in amount elements, be sure to indicate the percentage as a decimal. For example, 50 percent is .5, 25 percent is .25.
- For Medicare, the maximum number of characters that can be submitted in the dollar amount fields is seven characters. Claims in excess of 99,999.99 may be rejected. Also, claims that contain percentage amounts submitted with values in excess of 99.99 may be rejected.
- Most segments submitted at the claim level apply to the entire claim unless overridden by information submitted at the service line level.
- BCBSM, BCN and FEP claims requiring individual consideration (IC) or containing not otherwise classified procedure codes (NOC) **can be submitted electronically** by reporting supporting documentation in NTE segments, as needed in Loop\_2300 (can be used for IC) and Loop 2400 (must be used for NOC).
- Medical care visits for BCBSM claims must contain a "to" date of service when multiple days are reported on the same service line. New service lines are required when the level of care changes or there is an interruption in service dates.

### **Type of Service**

- BCBSM, BCN and FEP do not require that a type of service be reported in the professional 837 transaction set. For proper adjudication of your BCBSM, BCN and FEP claims, national modifiers should be reported. Some examples include services such as Durable Medical Equipment-DME (NU, BP, UE, BR/RR/LL), Technical Surgical Assistant-TSA (80, 81, 82), Professional or Technical Components (26, TC) and Ambulatory Surgical Centers (SG).

### **Character Set Requirement**

The following character set guidelines must be followed to avoid file rejections. Only characters identified below can be reported within any data field. Please note that any characters used as a delimiter cannot be reported within a data element. Reporting a special character within data elements when the character is also used as a delimiter in the transaction will cause compliance errors. Characters that are frequently used as delimiters have not been included in these guidelines and will result in individual claim rejection if used.

A...Z	0...9	!	“	&	,	(	)	+
'	-	.	/	;	?	=	@	Space

**Provider Identification Numbers**

The National Provider Identifier (NPI) is currently the primary identifier for providers. Provider taxonomy codes are required, as applicable. Only one occurrence of each qualifier is permitted when reporting multiple REF segments within any provider loop. Some situations (e.g. reporting of Medicare and Medicare DMERC provider IDs or BCN and some commercial provider IDs) may require submission of separate transactions or billing provider hierarchical levels.

**National Identifiers**

National Plan ID (Qualifier XV) is not used at this time.

**National Provider Identifier (NPI)**

The National Provider Identifier (NPI), must be reported as the primary identifier for a health care provider whenever a HIPAA mandated standard transaction is used. The only exception to this requirement is for providers that are not eligible to obtain an NPI. A qualifier of XX is required in NM108 of applicable provider loops to indicate that an NPI is present in NM109.

Group providers and incorporated individuals should report their Type 2 NPI in the NM109 position of loop 2010AA. The rendering providers Type 1 NPI would then be reported in the NM109 position of loop 2310B or 2420A as applicable. Individual or non-group providers should report their Type 1 NPI in the NM109 position of loop 2010AA.

BCBSM/BCN recommends that referring/ordering physicians share their NPI with the entity from whom your patients will receive additional services for use within their standard transactions.

NPI's are validated by BCBSM EDI for accuracy and that a match is made to a value registered in the EDI Provider Authorization database. To ensure that there is no interruption in receiving 835 remittance advice transactions, it is essential that when you add your NPI to the EDI Provider Authorization database that you also include your Unique Receiver ID (URI) by source of payment.

NPI's also need to be registered with BCBSM's provider enrollment area. For additional instruction regarding registering your NPI go to [www.bcbsm.com/provider/hipaa\\_npi/submit\\_npi.shtml](http://www.bcbsm.com/provider/hipaa_npi/submit_npi.shtml). Providers that only submit BCN claims must contact BCN at 800-255-1690 to complete their NPI registration.

**Claim Editing**

All professional claims are validated based on HIPAA medical code set and payer specific requirements. These requirements have been identified in the comment area of each affected field within the data clarification section.

- The following types of codes will be validated:
- ICD-9-CM (Volume 1 & 2) – diagnosis codes

- ICD-9-CM (Volume 3) – procedure codes
- HCPCS (Level 1 – CPT-4) – procedure codes
- HCPCS (Level 2) – procedure codes
- Modifiers (CPT)
- Modifiers (HCPCS)

Information regarding claims generating these edits will be returned in either an X12 Unsolicited 277 transaction or report file and affected claims will not be forwarded to the destination payer for processing. Edit messages and an example of the report are available in the Unsolicited 277 Companion Document and User Guide on the BCBSM web site at: [www.bcbsm.com](http://www.bcbsm.com).

### **Coordination of Benefits**

Follow the HIPAA Implementation Guide and additional instructions indicated below for COB reporting guidelines. Usage of the CAS segment should be made at the service (not claim) level. CAS adjustments reported at the claim level will not be recognized by BCBSM/BCN. Reporting of other payer amounts should occur at both the claim and service levels. Other payer amounts are reported in claims/service level AMT and SVD segments. Amounts reported at the claim level should be the sum of those equivalent amounts reported at the service level. Note: AMT and SVD segments are not needed for submission of BCBSM supplemental chiropractic x-ray claims. If submitted they should contain an amount of zero with appropriate CAS codes.

In cases where a capitation payment was received from the primary payer, the approved amount should be the entire charge. The prior paid amount should be the charge minus any patient co-pay amount.

At this time, BCBSM requires separate secondary claim submission for the following situations:

- On supplemental claims, when there is a combination of services that were paid and denied by Medicare as the primary payer.
- Supplemental chiropractic x-ray services.

These guidelines should be used for submission of secondary claims to all acceptable destination payers with the exception of Commercial carriers that do not accept electronically submitted secondary claims at this time.

The 837 transaction set contains numerous loops of data that must be completed accurately and reported in the correct sequence to ensure proper adjudication of a secondary claim. Listed below are specific reporting requirements, which will identify to the destination payer that you are submitting a secondary claim. These data elements may already be required, but contain different values on secondary claims or may be in addition to regularly required elements.

Loops 2000B, 2010BA and 2010BB are used to provide information regarding the secondary insured and destination payer. Loops 2300, 2320, 2330A, through H, 2400 and 2430 are used to provide information about the primary insured, payer and claim/service adjudication information.

Loop	Segment/ Element	Reporting Guidelines
2000B	SBR01	Report a value of S.
2000B	SBR05	Required for Medicare Secondary Payer (MSP) claims.
2000B	SBR09	Acceptable values are BL (Blue Shield); OF (FEP); HM (BCN) or BCN Advantage; MB (Medicare Part B including DMERC) or Medicare Advantage/Medicare Plus Blue (including DME); and MC, TV or 11 (Medicaid).
2300	CN1	On Medicare Secondary Payer (MSP) claims report a value of 09 in CN101 and the Obligated to Accept as Payment in Full (OTAF) amount in CN102 when not available at the service level. The OTAF amount is a payment (which is less than your charges) that you are obligated to accept or agreed to accept as payment in full satisfaction of the patient's payment obligation. In most cases, the OTAF amount is greater than the amount the primary payer actually paid on the claim. Medicare uses the OTAF amount(s) when calculating its secondary liability on such claims when services are paid on other than a reasonable charge basis.
2300	NTE02	On Medicare Secondary Payer (MSP) claims the address of the primary payer must be reported at either the claim or service level NTE segment. If either or both the primary paid amount or primary approved/allowed are zero, include an explanation in a claim or service level NTE segment (e.g. "Primary approved, but did not pay because total approved amount applied to deductible" or "Primary denied because..."). If the patient is only responsible for the managed care plan's co-pay amount, this should be indicated as follows in an NTE segment at either the claim or service level ("Billing for \$___ co-pay only"). Insert the co-pay amount in the narrative and report zeros as the primary paid and approved or allowed amounts.
2320	SBR01	Report a value of P.
2320	SBR02	Used to indicate the patient relationship to the other insured.
2320	SBR03	This data element is intended to be the insured's group number, not the number that uniquely identifies the insured.
2320	CAS	Used to provide primary payer claim adjudication reduction/denial reason codes and associated amounts. Claim adjustment amounts reported at the claim level are not the sum of service level amounts. Most payers, including BCBSM/BCN, require CAS information to be reported at the service level for proper adjudication.
2320	AMT	Amount segments at the claim level are used to report primary payer paid, allowed and approved amounts. The paid amount and either the allowed or approved amount must be reported and must equal the sum of the equivalent service level amounts. An amount of zero is acceptable. The claim charge minus all reported CAS adjustments must equal the claim level prior payer paid amount. The primary paid amount cannot exceed the primary allowed amount and the primary paid and approved/allowed amounts cannot exceed the billed amount.
2330A	NM109	Used to report the primary identifier of the other insured.
2330B	NM103	Used to report the name of the primary payer.
2330B	NM109	Medicare B and MDCH (Medicaid) have payer ID number lists that must be used for proper adjudication. Otherwise, report the most appropriate known value.
2330B	DTP03	Used to report the date the claim was paid by the primary payer.
2400	AMT	Used to provide service level approved amount. Sum of this amount from all service lines must equal the claim level approved/allowed amount. An amount of zero is acceptable.
2400	CN1	On Medicare Secondary Payer (MSP) claims report a value of 09 in CN101 and the Obligated to Accept as Payment in Full (OTAF) amount in CN102 when available at the service level. Refer to loop 2300, CN1 segment above for additional information.

Loop	Segment/ Element	Reporting Guidelines
2400	NTE02	On Medicare Secondary Payer (MSP) claims the address of the primary payer must be reported in either the claim or service level NTE segment. Refer to loop 2300, NTE02 for additional guidelines.
2430	SVD02	Used to provide service level primary payer paid amount. Sum of this amount from all service lines must equal the reported claim level paid amount.
2430	CAS	Used to provide primary payer service adjudication reduction/denial codes and associated amounts.
2430	DTP	Primary payer date claim paid is required for all secondary claims.

### **Submission of BCBSM/BCN Status Inquiry Claims**

#### **Electronic BCBSM status inquiry claims**

Submit when the provider disagrees with the initial determination for a claim, or for a particular service within a claim. In order for a status inquiry claim to be properly adjudicated, the following information must be included in your electronic claim in addition to all regularly required fields. When submitting a status inquiry on a supplemental or COB claim, all required fields for those types of claims must be submitted in addition to the fields required for submission of a status inquiry claim.

When sending a second 837, report one of the following values in CLM05-3 (if applicable):

- Use claim frequency code 7 to indicate payment other than anticipated (POTA)
- Use claim frequency code 7 for corrected claims.
- Use claim frequency code 8 to indicate replacement of a previously rejected claim
- Use claim frequency code 1 to indicate COMP NPR and submit as an original claim.

If a code value 7 or 8 is submitted, the original claim reference number (ICN/DCN) must be reported in Loop 2300, REF segment (Qualifier F8).

#### **Electronic BCN & BCN Advantage status inquiry claims**

Submit when the provider disagrees with the initial determination for a claim, or for a particular service within a claim. In order for a status inquiry claim to be properly adjudicated, the following information must be included in your electronic claim in addition to all regularly required fields.

When sending a second 837, report one of the following values in CLM05-3 (if applicable):

- Use claim frequency code 7 to indicate payment other than anticipated (POTA)
- Use claim frequency code 7 for corrected claims.
- Use claim frequency code 8 to void a claim submission.

If a claim frequency code 7 or 8 is submitted, the original claim reference number (ICN/DCN) must start with an E, M, or 0 (zero) followed by 11 digits and must be reported in Loop 2300, REF segment (Qualifier F8). BCN will accept value codes 7 or 8 for primary claims; secondary claims with value codes 7 or 8 must be submitted on paper as noted in the Professional Electronic Claim Exclusions section of this document.

For electronic Medicare Advantage/Medicare Plus Blue (including DME), status inquiry claims, use a claim frequency code 7 to indicate a replacement or void of a previous claim. If a claim frequency code 7 is submitted, the original claim reference number (ICN/DCN) must be reported in Loop 2300, REF segment (Qualifier F8).

## **Reporting Commercial Payer IDs and Claim Office Numbers**

The correct Payer ID and Claim Office Number when applicable must be reported in Loop 2010BB, NM109 and REF02 (Qualifier FY) in order for commercial payer claims to be routed correctly.

- See the Commercial Payer Table for a list of Payer Numbers and Claim Office Numbers.
- The EDI Commercial Payer Table Listing can be downloaded from the BCBSM web site at [www.bcbsm.com](http://www.bcbsm.com).
- If the Claim Office Number is blank or “0000” for a payer listed on the Commercial Payer List, then you should not report a Claim Office Number for that payer (REF segment with qualifier of FY should not be present).
- If there is a numeric claim office number for a payer on the Commercial Payer List, then the numeric claim office number shown should be reported on the claim.
- If “NOCD” is the claim office number shown for a payer on the Commercial Payer List, then “NOCD” should be reported as the claim office number on the claim.
- If there is a payer that is not shown on the Commercial Payer List that you wish to bill an electronic Commercial claim for, or if you submit your claims to a Payer whose address is different than what is shown on the list, contact the EDI Department at 800 542-0945 and select the option 2 for commercial payer IDs to arrange to have a payer number/claim office number assigned to the payer.

There is also a column on the payer list labeled “TY”. An “X” in this column indicates that although electronically submitted, claims are printed and mailed to the payer. An “E” in this column indicates that the claims submitted for that payer are processed electronically. A “D” in this column indicates that the claim is submitted directly to the payer by BCBSM EDI. Some payers are shown numerous times on the list as “All Claim Offices” and also with a different numeric payer ID. In these instances, any valid Claim Office Number can be reported.

## **Professional Electronic Claim Exclusions**

Although BCBSM is currently working toward eliminating the need for any type of hardcopy claim submissions, additional system renovation is required to eliminate all of the electronic exclusions that exist today. Please note that items on the list below cannot be submitted in the Professional 837 until further notice:

- BCBSM, FEP and BCN claims requiring hardcopy documentation
- BCBSM, FEP and BCN tertiary claims
- Commercial secondary or tertiary payer claims
- BCN status inquiry for secondary claims
- FEP COB and status inquiry claims
- BCBSM COB that are auto or employment related
- BCBSM rural health supplemental claims where the primary payer processed as a facility claim and the supplemental portion needs to be processed by BCBSM as professional. The primary payer (Medicare Part A) paid an amount higher than the original total charge.

## **EDI Clearinghouse Exclusions**

- Secondary or tertiary claims where loop 2000B/SBR09 (source of payment) = CI.

## **ANSI ASC X12N Professional 835 (004010X091A1) – Remittance Clarifications**

The addenda version of the ANSI ASC X12N 835-transaction set has been selected as the format to meet HIPAA requirements for the return of health care remittance advice. One 835 transaction set reflects a single check or EFT transfer. Multiple claims can be referenced within one 835. The 835 may or may not contain responses for all services

submitted within an individual claim and depends on how the claim is split by the adjudication system. This document provides information pertaining to 835s for BCBSM, Medicare Advantage/Medicare Plus Blue, BCN and NASCO (including FEP). Enveloping information only is provided for Medicare B (WPS). Trading partners should reference WPS's companion document for more detailed information regarding Medicare B 835's.

### **835 Balancing**

Three levels of balancing occur within the 835 transaction:

- **Transaction Set Balancing** – The total payment equals the sum of claim payments minus the sum of provider level adjustments.
- **Claim Level Balancing** – The total claim payment equals the submitted claim charge minus the sum of claim and service adjustments.
- **Service Level Balancing** – The service line payment equals the submitted service line charge minus the sum of service line adjustments.

Adjustments within the 835, through use of the Claim Adjustment and Service Adjustment Segments (CAS) or Provider Adjustment Segments (PLB) decrease the payment when the adjustment amount is positive, and increase the payment when the adjustment amount is negative.

Service detail will be reported in the 835 for all professional claims.

Though BCBSM Professional 835 adjustments are typically seen at a service level, if applicable, the Personal Savings Account (PSA)/Health Savings Account (HSA) will be returned at the claim level for out of state Blue Plan members.

For professional claims, all other reductions are reported at the service level. They may also used to differentiate between the units that were reported and the actual units that were used to adjudicate the claim/service. The adjustment group code is also indicated. The nature of the adjustment is identified by a standard list of adjustment reason codes published by the Washington Publishing Company ([www.wpc-edi.com](http://www.wpc-edi.com)).

Provider level adjustments include remittance information that is not specific to the claim(s)/service(s) contained in the prior level of the 835 transaction. These provide for reporting increases or reductions to the amount remitted. Reference numbers are used for further identification and reconciliation.

The total payment will agree with the remittance detailing that payment.

### **Maximums/Limitations**

The total payment amount will not exceed ten numeric characters (9999999.99). The 835 will not be issued for less than zero dollars. There is a recommended maximum of 10,000 claim payment segments (CLM) per transaction set.

### **Provider Identification Numbers**

The National Provider ID (NPI) is currently the primary identifier for providers. Secondary identifiers may also be present, but specific identifiers to qualify the code such as Blue Cross or Blue Shield provider codes are not advised at that level. The identifiers supported are the state license number or a generic Payee Identification, which will be used to return the provider number. Provider numbers or state license numbers may also be used to identify a rendering provider.

## **Payee Identification**

Payee Address information (Loop 1000B, Segments N3 and N4) may not be returned.

## **Control/Reference Numbers**

If reported in the claim, the line item control number will be returned in the electronic remittance file. When not reported, the original service line number may be returned as the line item control number.

## **Claim and Service Level Information**

- A Claim Status Code is used to identify the status of the entire claim as assigned by the payer. Possible status codes describe the following conditions: processed as primary, processed as secondary, processed as tertiary, denied, reversal of previous payment, predetermination pricing only, processed as primary, secondary or tertiary and forwarded to additional payer(s) and not our claim, forwarded to additional payer(s).
- Patient Responsibility Amount will balance to supporting claim/service level adjustments.
- The individual claim payment may be zero or less than zero, but the 835 total payment amount will not be issued for less than zero dollars.
- Corrected insured name or identification number is provided when available.
- The status of a non-adjudicated claim will be returned in an Unsolicited 277 Health Care Claim Status Notification Transaction Set or a report file. This transaction is not mandated by HIPAA legislation.
- When the current payer believes that another payer has priority for making a payment, the name and ID number of that payer may be returned. The ID number returned is an internal number the payer uses to recognize a payer or in some cases could be the payer's name.

## **Bundling and Unbundling**

Bundled and unbundled information will be reported back if applicable. When codes are bundled, the code submitted, adjudicated code and total payment amount would be reported. All other lines will contain the code submitted, adjudicated code and payment amount of \$0.

## **Claim/Service Adjustments**

- For 835s coming from other payers, both the Claim Adjustment and Service Adjustment Segments may be used to provide the reasons, amounts and quantities of any adjustments that the payer made either to the original submitted charge or to the units related to the claim or service(s).
- For 835s coming from BCBSM, Medicare Advantage/ Medicare Plus Blue, NASCO/FEP, only Service Adjustment Segments will provide the reasons, amounts and quantities of any adjustments that the payer made either to the original submitted charge or to the units related to the claim or service(s).
- BCBSM Professional 835 adjustments are typically seen at a service level, if applicable, the Personal Savings Account (PSA)/Health Savings Account (HSA) will be returned at the claim level for out of state Blue Plan members.
- The summation of the adjustments at the claim and service levels is the total adjustment for the entire claim.
- Service level adjustments are not repeated at the claim level.
- A standardized list of claim adjustment reason codes is used in the Claim Adjustment and Service Adjustment Segments. These codes provide a standard "explanation" for the positive or negative financial adjustments specific to particular claims or services that are referenced in the transmitted 835.

- A Claim Adjustment Group Code categorizes the adjustment reason codes that are contained in a particular adjustment segment. Up to six different adjustments related to a particular Claim Adjustment Group may be reported per segment.
- Remark codes (LQ segment) further describes reasons for an adjustment to the change when applicable.

### **Claim Interest and Prompt Payment Discounts**

Payer-provider level interest and prompt payment discounts refer to adjustments that specific payer and provider contractual agreements require. Such adjustments are financially independent from the formula for determining benefit payments and are reported at the provider adjustment level. This information will also be provided in an amount segment at the claim level without affecting balancing.

### **Reversals and Corrections**

Reversals and corrections will be handled by reversing the original claim payment and re-sending the corrected data.

### **Claim Splitting by Payers**

When the adjudication system requirements result in services submitted within one claim being split into multiple claims, the payer will retain and return basic original claim information in each of the adjudicated claims. The original Claim Submitter's Identifier and line item control numbers will be returned.

### **Blue Exchange**

835 transactions for supplemental claims processed by other Blue Cross Blue Shield plans are now available through BlueExchange. In order to begin receiving these transactions, providers must register their tax identification number and NPI with the BCBSM EDI department.

### **Additional Information**

#### **TA1 Interchange Acknowledgements**

Interchange Acknowledgements are used to reply to an interchange or transmission that has been sent. This acknowledgement provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure and verifies the envelope information. It may also be used by EDI to identify a duplicate file or other file level rejections. Refer to Appendix A and B of the ANSI ASC X12N HIPAA Implementation Guides for additional terminology, summaries and format information for the TA1 Interchange Acknowledgement. Interchange acknowledgement (TA1) transactions are only provided when requested in the Interchange Control Header, to identify interchange control structure errors or to identify duplicate interchanges.

#### **997 Functional Acknowledgements**

Functional Acknowledgements are used to facilitate control of EDI. Segments within the 997 are used to identify the acceptance or rejection of functional groups, transaction sets or segments. Data elements in error can also be identified. The sending trading partner can determine if the receiving trading partner has received the transaction sets that

they sent. Use of this process is essential for successful reconciliation and follow-up of EDI. Refer to Appendix A and B of the ANSI ASC X12N HIPAA Implementation Guides for additional terminology, summaries and format information for the 997 Functional Acknowledgement.

Please note that BCBSM will be returning 997 functional acknowledgements on a daily basis to verify receipt of files from trading partners and expects to receive 997 functional acknowledgements from trading partners to acknowledge receipt of files that BCBSM has sent to them. Such usage of the 997 is necessary for reconciliation purposes.

### **Unsolicited Claim Status (277)**

The Unsolicited Claim Status (277) transaction or a report file (U277B, U277C, U277F, U277H, U277L and U277O) will be used by EDI to notify submitters of front end claim editing conditions encountered on claims submitted within the 837 transaction. An EDI companion document for this transaction and the EDI User Guide which contain edit lists with descriptions are available on our web site at [www.bcbsm.com](http://www.bcbsm.com). The Standard Implementation Guide for 003070 Unsolicited 277 and Standard Health Care Claim Status Codes that are used in the Unsolicited 277 are available from the Washington Publishing Company web site at [www.wpc-edi.com](http://www.wpc-edi.com).

### **Professional 837 and 835 Interchange Envelope and Functional Group Structure**

Trading partners should follow the Interchange Control Structure (ICS), Functional Group Structure (GS), Interchange Acknowledgement (TA1) and Functional Acknowledgement (997) guidelines for HIPAA that are located in the HIPAA Implementation Guides in Appendices A and B. Trading partners should also follow the basic character set guidelines as set forth in the implementation guide. The interchange cannot contain non-HIPAA version functional groups. Unique instructions for transmitting to BCBSM EDI are:

Transaction Set	Element	Instruction	Pg#
Professional 837 Health Care Claim	ISA05 – Interchange ID Qualifier	Report ZZ.	B.4
Professional 837 Health Care Claim	ISA06 – Interchange Sender ID	Report the EDI-assigned Billing Location Code of the submitter.	B.4
Professional 837 Health Care Claim	ISA07 – Interchange ID Qualifier	Report ZZ.	B.4
Professional 837 Health Care Claim	ISA08 – Interchange Receiver ID	Report 382069753.	B.5
Professional 837 Health Care Claim	GS02 – Application Sender’s Code	Report the EDI-assigned Billing Location Code of the submitter.	B.8
Professional 837 Health Care Claim	GS03 – Application Receiver’s Code	Report 382069753.	B.8
Professional 837 Health Care Claim	GS08 – Version/Release/Industry ID Code	Report 004010X098A1	B.8
Professional 835 Health Care Claim Payment Advice	ISA05 – Interchange ID Qualifier	ZZ will be returned from EDI.	B.4
Professional 835 Health Care Claim Payment Advice	ISA06 – Interchange Sender ID	382069753 will be returned from EDI.	B.4
Professional 835 Health Care Claim Payment Advice	ISA07 – Interchange ID Qualifier	ZZ will be returned from EDI.	B.4
Professional 835 Health Care Claim Payment Advice	ISA08 – Interchange Receiver ID	The URI (Unique Receiver ID) designated by the provider based on source of payment will be returned.	B.5

Transaction Set	Element	Instruction	Pg#
Professional 835 Health Care Claim Payment Advice	GS02 – Application Sender’s Code	One of the following application system identifiers will be returned for BCBSM-related 835 functional groups: Professional NASCO and FEP: BCBSM NASCO Professional BCBSM and MESSA: BCBSM LOCAL PRO Professional MOS: BCBSM MOS BCN: FACETSTHG Professional Master Medical: BCBSM MSTMD PRO Medicare (WPS): 00953 Medicare Advantage/Medicare Plus Blue: MED ADVANTAGE Professional BCBSM and MESSA: BCBSM LOCAL SUB (pay subscriber claims).	B.8
Professional 835 Health Care Claim Payment Advice	GS03 – Application Receiver’s Code	The same value as in ISA08 will be returned.	B.8
Professional 835 Health Care Claim Payment Advice	GS08 – Version/Release/Industry ID Code	004010X098A1 will be returned.	B.8

### **Data Clarifications for the Professional 837 (004010X098A1) Transaction Set**

Loop	Segment/Element	Instruction	Industry/Element Name
N/A	BHT02	<b>All Files</b> – Any files containing Medicare and Medicare DMERC claims must indicate 00 (Original) in this element. This element will not be referenced for files containing BCBSM, FEP and/or BCN claims.	Transaction Set Purpose Code
N/A	BHT04	<b>All Files</b> – Must be less than or equal to the current date.	Transaction Set Creation Date
N/A	BHT06	<b>All Files</b> – Any files containing Medicare and Medicare DMERC claims must indicate CH (Chargeable) in this element. This element will not be referenced for files containing BCBSM, FEP and/or BCN claims.	Claim or Encounter Identifier
All	AMT	<b>Medicare and Medicare DMERC</b> – The maximum numbers of characters to be submitted in the dollar amount field are seven characters. Claims in excess of 99,999.99 may be rejected.	Amount Elements
1000A	NM104	<b>All Payers</b> – Required if NM102 equals 1. Must not be present if NM102 equals 2.	Submitter First Name
1000A	NM109	Report the BCBSM EDI-assigned billing location code of the submitter.	Submitter Primary ID Number
1000B	NM103	Report BCBSM as the receiver name.	Name Last/Org Name
1000B	NM109	Report 00710 as the receiver identification code for files directed to BCBSM as a clearinghouse or as a payer.	ID Code

Loop	Segment/Element	Instruction	Industry/Element Name
2000A	All	<p><b>All Payers</b> – Use the Billing Provider Hierarchical Level (HL) to identify the original entity that submitted the electronic claim/encounter to the destination payer identified in Loop ID-2010BB. The billing provider entity may be a health care provider, a billing service, or some other representative of the provider.</p> <p>The Billing/Pay-to Provider HL may also contain information about the pay-to provider entity. If the pay-to provider entity is the same as the billing provider entity, then only use Loop ID-2010AA.</p> <p>If the billing or pay-to provider is also the rendering provider and Loop ID-2310B is not used, the Loop ID-2000 PRV must be used to indicate which entity (Billing or Pay-to) is the Rendering Provider.</p> <p><b>BCBSM, Medicare Advantage/Medicare Plus Blue (including DME), BCN, BCN Advantage and FEP</b> – Any entity reported other than the billing provider will not be recognized. Payments will continue to be directed to the provider indicated in corporate provider databases. If reported, the Pay-to provider will not be recognized/used. For BCN, BCN Advantage and Medicare Advantage/Medicare Plus Blue (including DME), if reported, secondary identifiers for the Pay-to provider will be validated. Foreign addresses cannot be reported.</p>	Billing/Pay-to Provider Hierarchical Level Loop
2000A	PRV01, PRV02, PRV03	<p>Required when adjudication is known to be impacted by the provider taxonomy (type) code and the billing or pay-to provider is also the rendering provider. A list of taxonomy codes is available at the Washington Publishing Company web-site: <a href="http://www.wpc-edi.com">www.wpc-edi.com</a>.</p> <p><b>BCBSM and Medicare Advantage/Medicare Plus Blue (including DME)</b> – Use PRV segment in 2310B when reporting rendering provider taxonomy for group providers (2010AA/NM102=2).</p> <p><b>BCBSM</b> – Chiropractic providers must report a valid taxonomy code on supplemental x-ray claims at either the billing provider, claim or service level to identify these specific supplemental claims. Note: Supplemental chiropractic x-ray services cannot be submitted on the same claim with other services. A separate claim containing only the chiropractic x-ray services is required.</p> <p>Valid code values are:                      111N00000X = Chiropractic                      111N10900X = Internist                      111NN0400X = Neurology                      111NN1001X = Nutrition                      111NX0100X = Occupational Medicine                      111NX0800X = Orthopedic                      111NR0200X = Radiology                      111NS0005X = Sports Physician                      111NT0100X = Thermography</p>	Provider Code, Reference Identification Qualifier, Provider Taxonomy Code
2000A	CUR	<p><b>All Payers</b> – For proper adjudication, we recommend not reporting a CUR segment. Foreign currency claims should be reported using a paper submission.</p>	Currency Segment
2010AA	NM104	<p><b>All Payers</b> – Required if NM102 equals 1. Must not be present if NM102 equals 2.</p>	Billing Provider First Name

Loop	Segment/Element	Instruction	Industry/Element Name
2010AA	NM108, NM109	<p><b>All Payers</b></p> <ul style="list-style-type: none"> <li>When NM108 qualifier=XX then NM109 must contain the 10 digit numeric National Provider Identifier (NPI)</li> <li>Either the EIN or SSN of the Billing provider must be reported in the REF01/REF02 of this loop. For information regarding NPI billing requirements, reference the National Provider Identifier (NPI) section on page 6 of this document.</li> </ul> <p><b>Commercial</b> – The billing provider’s NPI will be validated when commercial claims are submitted.</p>	Billing Provider ID, Billing Provider Secondary ID
2010AA	REF01, REF02	<p>Required when a secondary identification number is necessary to identify the entity. The primary identification number is reported in NM108/NM109 in this loop. BCBSM EDI, the destination payer or both entities will validate the Billing Provider’s Secondary Identification Number. To avoid unnecessary claim rejections, report all applicable identification numbers associated with the claims submitted for the billing provider.</p> <p><b>All Payers</b> – A REF segment with qualifier EI=EIN or SY=SSN and the 9 digit numeric Employer Identification Number (EIN) or the Social Security Number (SSN) of the Billing Provider are required for the billing provider.</p> <p><b>Commercial</b> – Use qualifier G2 or other qualifier as applicable to report the number assigned to the billing provider by the Commercial Payer. Separate transactions or billing provider hierarchical levels must be submitted when filing claims for more than one of the following commercial payers:  <b>Cofinity/PPOM – EIN/SSN must match number on the PPOM provider file.</b></p>	Qualifier and Billing Provider Secondary ID
2010AA	REF01, REF02	<b>All Payers</b> – Credit/Debit card information may not be used for any insurance payer.	Credit/Debit Card Information
2010AB	All segments	<b>BCBSM, BCN and FEP</b> – Segments within this loop are not referenced, if reported.	
2010AB	NM101 through NM104	<p><b>All Payers</b> – NM104 is required if NM102 equals 1. Must not be present if NM102 equals 2.</p> <p><b>Commercial</b> – Required if the pay-to provider is a different entity than the billing provider.</p>	Pay-to Provider Name
2010AB	NM108, NM109	<p><b>All Payers</b> –</p> <ul style="list-style-type: none"> <li>NM108-Report qualifier (XX=NPI)</li> <li>When NM108 qualifier=XX then NM109 must contain the 10 digit numeric National Provider Identifier (NPI)</li> </ul> <p><b>Commercial</b> – Required for entering the pay-to provider NPI (Qualifier XX), if the billing provider and pay-to providers are different.</p>	Pay-to Provider ID
2010AB	N301, N302, N401, N402, N403	<b>Commercial</b> – Required for entering the address of the pay-to provider. Zip code must match state. For locations out of the U.S., indicate XX in N402.	Pay-to Provider Address
2010AB	N404	<b>Commercial</b> – Required when N402 is XX.	Pay-to Provider Country Code
2010AB	REF02	<b>All Payers</b> –Report additional REF segment with qualifier EI=EIN or SY=SSN and the 9 digit numeric Employer Identification Number (EIN) or the Social Security Number (SSN) of the Pay To Provider.	Pay-to Provider Secondary ID

Loop	Segment/Element	Instruction	Industry/Element Name
2000B	SBR01	<p><b>All applicable Payers</b> – Whenever secondary (SBR01 equals S) or tertiary (SBR01 equals T); loop 2320 must be present for each of the prior payers.</p> <p><b>BCBSM, BCN and FEP</b> – Cannot equal T.</p> <p><b>FEP</b> – Can only equal S if primary payer is Medicare.</p> <p><b>BCN</b> – Must equal P or S when SBR09 equals HM.</p> <p><b>Medicare</b> – If SBR01 equals P then SBR05 must not be used.</p> <p><b>Medicare Advantage/Medicare Plus Blue</b> – Can be P or S.</p> <p><b>MDCH (Medicaid)</b> – Use P if MDCH (Medicaid) is the only payer, S if there is one other payer primary to MDCH (Medicaid) or T if there are two or more other payers primary to MDCH (Medicaid).</p> <p>If SBR01 equals S or T then either 2330B/DTP segment with qualifier of 573 or 2430/SVD segment for each reported service is required.</p> <p><b>Commercial</b> – Must equal P when SBR09 equals CI.</p>	Payer Responsibility Sequence Number Code
2000B	SBR02	<p><b>All Payers</b> – If subscriber is the patient (SBR02 equals 18) then 2010BA/N301, N401, N402, DMG02 and DMG03 must be present. When reported in loop 2000B must always be equal to 18.</p> <p><b>BCBSM</b> – If subscriber is the patient (SBR02 equal to 18), do not use loop 2010CA unless claims are being submitted for the subscriber and one or more dependents.</p> <p><b>Medicare, Medicare Advantage/Medicare Plus Blue, Medicare DMERC (including DME), and MDCH (Medicaid)</b> – For Medicare, Medicare DMERC and MDCH (Medicaid), the subscriber is always the same as the patient. SBR02 must equal 18.</p> <p><b>BCN and BCN Advantage</b> – To ensure proper processing; only report when the insured is the patient.</p>	Relationship Code
2000B	SBR04	<b>Commercial</b> – Required by most commercial payers.	Insured Group Name
2000B	SBR05	<b>Medicare</b> – Required when the destination payer (Loop 2010BB) is Medicare and Medicare is not the primary payer (SBR01 equals S or T). See Implementation Guide for a list of valid code values.	Insurance Type Code
2000B	SBR09	<p>Claim Filing Indicators determine the destination payer to whom the claim will be routed by the EDI Clearinghouse and, must correspond to the destination payer ID reported in loop 2010BB. For proper claim routing and adjudication use only the following codes:</p> <p>BL – Blue Shield (including Blue Card claims)</p> <p>CI – Commercial and any other HMOs besides Blue Care Network</p> <p>HM – Blue Care Network and BCN Advantage</p> <p>MB – Medicare B and Medicare Advantage/Medicare Plus Blue (including DME).</p> <p>MC – MDCH (Medicaid)</p> <p>TV – Title V</p> <p>11 – State Medical Plan (Other Non-Federal)</p> <p>OF – Federal Employee Program (FEP)</p> <p><b>BCN</b> – Routine vision services should be billed under BL (Blue Shield). Medical vision and all other services for BCN members should be billed under HM (BCN). <b>Commercial and HMOs that are not BCN</b> – Indicate CI. Whenever SBR09 equals CI then SBR01 must equal P.</p> <p><b>FEP</b> – Must indicate OF. Do not use BL.</p> <p><b>MDCH (Medicaid)</b> – In most cases, use MC. TV and 11 also accepted. If recipient qualifies for more than one program, or other Michigan Department of Community Health program not listed, use MC.</p>	Claim Filing Indicator

Loop	Segment/Element	Instruction	Industry/Element Name
2010BA	NM102	<b>BCBSM, BCN, BCN Advantage FEP, Medicare, Medicare Advantage/Medicare Plus Blue</b> (including DME), <b>Medicare DMERC and Medicaid (MDCH)</b> – Must equal 1. <b>Commercial</b> – Must equal 1 except for workman’s compensation claims.	Entity Type Qualifier
2010BA	NM103	<b>All Payers</b> – Must be alphabetic and cannot contain embedded spaces.	Subscriber’s Last Name
2010BA	NM104	<b>All Payers</b> – Do not report numbers or special characters. Must be alphabetic. Do not report numbers, embedded spaces or special characters	Subscriber First Name
2010BA	NM109 Qualifier MI	Required if the subscriber is the patient. If the subscriber is not the patient, use if known or when needed by the payer to identify the subscriber. <b>BCBSM, Medicare Advantage/Medicare Plus Blue</b> (including DME), <b>BCN and BCN Advantage</b> – Required on all claims. Report the alphabetic prefix followed by the contract number. May be up to 17 characters including the alphabetic prefix and may contain alphabetic characters within the contract number positions. <b>FEP</b> – Required on all claims. Must be an R followed by 8 digits. <b>Medicare and Medicare DMERC</b> – Enter the patient’s Medicare Health Insurance Claim Number (HICN). <b>MDCH (Medicaid)</b> – Enter the patient’s 10 digit member ID number assigned by MDCH (Medicaid). <b>Medicare and MDCH (Medicaid)</b> – For Indian Health Services, enter the 3 digit tribe ID followed by the 7 digit residency code. These numbers are obtained from the authorizing service that referred the patient for services. Format as: <ul style="list-style-type: none"> <li>• Community – 3 digits</li> <li>• County – 2 digits</li> <li>• State – 2 digits</li> </ul> <b>Commercial</b> – Either loop 2010BA/NM109 or 2010CA/NM109 must be present.	Subscriber Identification
2010BA	N301, N302, N401, N402, N403	<b>All Payers</b> – Required when the subscriber is the patient (loop 2000B/SBR02 equals 18). <b>BCBSM</b> – These elements should be completed if the provider is non-par and is not participating on this claim on a per-claim basis (pay-sub claims). Foreign addresses cannot be reported.	Subscriber Address
2010BA	N404	<b>Commercial</b> – Required when N402 is XX.	Subscriber Country Code
2010BA	DMG02	<b>All Payers</b> – Required when the subscriber is the patient (loop 2000B/SBR02 equals 18.) Must be less than or equal to the current date.	Subscriber Date of Birth
2010BA	DMG03	<b>All Payers</b> – Required when the subscriber is the patient (loop 2000B/SBR02 equals 18.) <b>BCBSM</b> – Must be M or F.	Subscriber Gender Code
2010BA	REF01, REF02	<b>Medicare and MDCH (Medicaid)</b> – For Indian Health Services, use qualifier 23 in REF01 and enter the Health Record Number in REF02.	Subscriber Secondary ID
2010BB	NM108	<b>All Payers</b> – Report qualifier PI.	

Loop	Segment/Element	Instruction	Industry/Element Name
2010BB	NM109 Qualifier PI	<p>Must correspond to the Claim Filing Indicator reported in SBR09 of loop 2000B.</p> <p><b>BCBSM, FEP, Medicare Advantage/Medicare Plus Blue, BCN and BCN Advantage</b> – This element must equal 00710 when the Claim Filing Indicator (2000B-SBR09) is BL (Blue Shield including Blue Card claims). OF (FEP), MB for Medicare Advantage/ Medicare Plus Blue or HM (Blue Care Network/BCN Advantage). For Blue Card claims, report 00710.</p> <p><b>Commercial</b> – This element must contain a valid Payer ID number assigned to the commercial payer as shown on the EDI Commercial Payer Table Listing. The Payer Claim Office number (loop 2010BB-REF02 and Qualifier = FY) will identify the specific payer location responsible for processing the claim, when applicable. The EDI Commercial Payer Table Listing can be downloaded from the BCBSM web site at <a href="http://www.bcbsm.com">www.bcbsm.com</a>. See Overview Section of this document for additional information on reporting commercial payer IDs and claim office numbers.</p> <p><b>Medicare</b> – This element must equal 00953 when the Claim Filing Indicator Code (2000B-SBR09) is MB (Medicare).</p> <p><b>Medicare B DMERC</b> – This element must equal 17003 when the Claim Filing Indicator Code (2000B-SBR09) is MB (Medicare) and the claim is for Durable Medical Equipment.</p> <p><b>Medicare Advantage DME</b> – This element must equal MADME when the Claim Filing Indicator Code (2000B-SBR09) is MB (Medicare) and the claim is for Durable Medical Equipment.</p> <p><b>MDCH (Medicaid)</b> – This element must equal D00111 when the Claim Filing Indicator Code (2000B-SBR09) is MC (MDCH (Medicaid)), TV (Title V) or 11 (State Medical Plan).</p>	Payer ID
2010BB	REF02 Qualifier FY	<p><b>Commercial</b> – When applicable, report FY in REF01 and the Claim Office Number of the commercial carrier as shown on the EDI Commercial Payer Table Listing in the corresponding REF02. The EDI Commercial Payer Table Listing can be downloaded from the BCBSM web site at <a href="http://www.bcbsm.com">www.bcbsm.com</a>. See Overview Section of this document for additional information on reporting commercial payer IDs and claim office numbers.</p>	Claim Office Number
2010BC	N301, N302, N401, N402, N403	<p><b>Commercial</b> – If entered, the zip code must match the state. For locations out of the U.S., indicate XX in N402.</p>	Responsible Party Address
2010BC	N404	<p><b>Commercial</b> – Required when N402 is XX.</p>	Responsible Party Country Code
2010BD	NM101-NM109	<p><b>All Payers</b> – Credit/Debit card information may not be used to bill any insurance payer.</p>	Credit/Debit Card Holder Name
2000C	All	<p><b>Medicare, Medicare Advantage/Medicare Plus Blue (including DME), Medicare DMERC and MDCH (Medicaid)</b> – For Medicare and MDCH (Medicaid), the subscriber is always the same as the patient; therefore, the Patient Hierarchical (2000C) is not used.</p> <p><b>BCBSM, BCN, BCN Advantage, FEP and Commercial</b> – Required if the patient is not the subscriber.</p>	Patient Hierarchical Level
2000C	PAT01	<p><b>All Payers</b> – Must be a valid code value. See Implementation Guide for a list of valid code values.</p>	Individual Relationship Code
2010CA	NM102	<p><b>BCBSM</b> – Must be equal to 1.</p>	Entity Type Qualifier
2010CA	NM104	<p><b>All Payers</b> – Required if NM102 equals 1.</p>	Patient First Name
2010CA	NM109	<p>Required <u>only</u> if the patient identifier is different than the subscriber ID reported in Loop 2010BA.</p> <p><b>BCBSM, FEP and BCN</b> – Report in 2010BA subscriber loop whether the subscriber is the patient or not.</p> <p><b>Commercial</b> – Either loop 2010BA/NM109 or 2010CA/NM109 must be present.</p>	Patient ID

Loop	Segment/Element	Instruction	Industry/Element Name
2010CA	N301, N302, N401, N402, N403	<b>Commercial</b> – If entered, the zip code must match the state. For locations out of the U.S., indicate XX in N402. Required for claims that will be printed and mailed to the destination payer when the patient is not the subscriber.	Patient Address
2010CA	N404	<b>Commercial</b> – Required when N402 is XX.	Patient Country Code
2010CA	DMG02	<b>All Payers</b> – Must be less than or equal to the current date.	Patient Date of Birth
2010CA	DMG03	<b>BCBSM</b> – Must be M or F.	Patient Gender Code
2300	CLM02	<b>All Payers</b> – Total submitted charges must equal the sum of the line item charge amounts (2400/SV102). <b>Medicare</b> – Negative values are not valid for this element.	Total Claim Charge Amount
2300	CLM05-1	<b>All Payers</b> – Must be a valid code.	Facility Type Code
2300	CLM05-3	<b>BCBSM</b> – These systems will not recognize void transactions for replacement transactions or for refund transactions. When sending a second 837, report one of the following values in CLM05-3 (if applicable): Use a claim frequency code 7 to indicate payment other than anticipated (POTA) Use a claim frequency code 7 for corrected claims. Use a claim frequency code 8 to indicate replacement of a previously rejected claim. Use a claim frequency code 1 to indicate COMP NPR and submit as an original claim. If a claim frequency code 7 or 8 is used, the original claim DCN must be reported in the REF segment (Qualifier F8). For BCN, this is valid only when BCN is primary. <b>Medicare Advantage/Medicare Plus Blue</b> (including DME) – Use a claim frequency code 1, 7 or 8. If a claim frequency code 7 or 8 is used please report an original claim DCN in the REF segment (Qualifier F8). <b>BCN and BCN Advantage</b> – For electronic BCN status inquiry claims where a service was denied or the payment received is other than anticipated, use a claim frequency code 7. To void a claim use a claim frequency code 8. If a claim frequency code 7 or 8 is submitted, the original claim reference number ICN/DCN (must start with an E, M, or 0 (zero) followed by 11 digits) must be reported in Loop 2300, REF segment (Qualifier F8). See Overview Section of this document for additional information on reporting BCBSM and BCN status inquiry claims. <b>BCN and BCN Advantage</b> – Claim frequency codes of 7 or 8 must be submitted via paper when BCN is secondary. <b>Medicare and Medicare DMERC</b> – Use values of 1 (Original) or 7 (Replacement) only. Claims with a value of 7 will be processed as original claims and may result in duplicate claim rejection. The claims processing system does not process electronic replacements. <b>MDCH (Medicaid)</b> – Use value of 1 on original claim submissions. Use 7 for claim replacement and 8 for void/cancel and report original Claim Reference Number (CRN) as specified in loop 2300. <b>Commercial</b> – Claims submitted with values 7 or 8 will be processed as originals.	Claim Frequency Type Code
2300	CLM06	<b>BCBSM</b> – Used to indicate that provider signature authorization form is on file at BCBSM EDI to submit claims electronically. <b>Medicare Advantage/Medicare Plus Blue</b> (including DME) – Report the provider signature indicator with a ‘ Y’	Provider Signature on File

Loop	Segment/Element	Instruction	Industry/Element Name
2300	CLM11	<b>BCBSM</b> – Secondary claims resulting from either auto or employment related accidents (code values AA or EM) are not allowed when the prior payer is other than Medicare. CLM11-1, 11-2 or 11-3 required when accident date is present (DTP01/439 qualifier). CLM11-4 required when CLM11-1, 11-2 or 11-3 is equal to AA. <b>MDCH (Medicaid)</b> – CLM11-4 is required when loop 2300/CLM11-1, 11-2 or 11-3 equals AA.	Accident/Employment/Related Causes
2300	CLM16	<b>BCBSM and FEP</b> – Non-par providers that are participating on a per claim basis must report P. Dental providers submitting professional services should report a P when they want the payment direction to be issued to the provider rather than the patient.	Par Indicator
2300	CLM20	<b>All Payers</b> – Data submitted in CLM20 (Delay Reason Code) may not be used for processing.	Delay Reason Code
2300	DTP03 Qualifier 454	<b>BCBSM</b> – Used to indicate the initial dialysis treatment date on ESRD claims (DTP01=454).	Date – Initial Treatment
2300	DTP03 Qualifier 304	<b>BCBSM</b> – For hearing services, report the date that a medical physician performed the medical evaluation exam, which is a prerequisite for receiving hearing benefits.	Date Last Seen
2300	DTP03 Qualifier 439	<b>BCBSM</b> – Required when accident indicator (11-1, 11-2 or 11-3) is present and equal to AA, AP or OA. <b>Medicare Advantage/ Medicare Plus Blue</b> (including DME) – Required when accident indicator (2300/CLM11-1, 2 or 3) is present. <b>Commercial</b> – Required when accident indicator (2300/CLM11-1, 2 or 3) is present.	Accident Date
2300	DTP03 Qualifier 435	<b>All Payers</b> – Must be less than or equal to the current date. <b>Commercial</b> – Required when the place of service in CLM05-1 is 21, 31, 51, 52 or 61. Admission date must not be after the service date.	Admission Date
2300	DTP03 Qualifier 090 and 091	<b>Medicare and MDCH (Medicaid)</b> – Required for situations where providers share post-operative care. When a surgeon submits the claim, 091 is used in DTP01 to show the date care was relinquished to another physician. When the second physician submits the claim, 090 is used to indicate the date care was assumed for the patient.	Assumed Care and Relinquished Care Dates
2300	PWK and NTE Segments	<b>BCBSM, BCN, BCN Advantage, Medicare Advantage, FEP (including DME) and MDCH (Medicaid)</b> – The NTE segment should be used when, in the opinion of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere within the claim data set. The NTE segment is equivalent to what providers previously referred to as “Notepad”. The NTE segment in loops 2300 or 2400 should be used to report supporting documentation for individual consideration (IC) and only in loop 2400 to report the procedure description for Not Otherwise Classified (NOC) procedures. When using the NTE segment, report qualifier ADD in NTE01. <b>BCBSM, BCN, BCN Advantage, FEP, Medicare, Medicare DMERC and Commercial</b> – Any data submitted in the PWK (Paperwork) segment may not be considered for processing. <b>Medicare</b> – Refer to section indicating guidelines for submission of secondary claims for specific reporting instructions. <b>Medicaid</b> – For Indian Health Services, use the NTE segment to report purchase order numbers. <b>Commercial</b> – Use the NTE segment in loop 2400 when the procedure code is “Not otherwise classified”.	Paperwork and Billing Notes (Claim and Service Level)
2300	CN1	<b>Medicare</b> – On Medicare Secondary Payer (MSP) claims, report a value of 09 in CN101 and the claim total Obligated to Accept as Payment in Full (OTAF) amount in CN102. Should be used when service level OTAF is not available. Refer to Coordination of Benefits section for specific reporting instructions.	Contract Type Code

Loop	Segment/Element	Instruction	Industry/Element Name
2300	AMT01, AMT02	<b>All Payers</b> – Credit/Debit card information may not be used for any insurance payer.	Credit Card Maximum Amount
2300	AMT Segment Qualifier F5	<b>Medicare</b> – Required if the patient has paid any amount towards the claim. <b>Medicare and Medicare DMERC</b> – Negative values are not valid for this element and could result in the claim being rejected.	Patient Amount Paid
2300	AMT02 Qualifier NE	<b>Medicare and Medicare DMERC</b> – Negative values are not valid for this element and could result in the claim being rejected.	Total Purchased Service Amount
2300	REF02 Qualifier EW	<b>Medicare</b> – If the supplier is a certified mammography screening center, enter the FDA approved certification number. When more than one supplier is used, a separate claim should be used to bill for each supplier.	Mammography Certification Number
2300	REF02 Qualifier G1	<b>MDCH (Medicaid)</b> – Use qualifier G1 in REF01 and report the 9 digit prior authorization number assigned by MDCH (Medicaid) in REF02. Qualifier 9F will not be recognized. <b>BCBSM</b> – Use qualifier G1 in REF01 and report the Prior Authorization in REF02. For proper adjudication, BCBSM recommends reporting at this level (the claim level) rather than the service level (loop 2400). <b>Medicare and MDCH (Medicaid)</b> – For Indian Health Services, use qualifier G1 in REF01 and enter the purchase order number in REF02.	Prior Authorization Number
2300	REF02 Qualifier F8	<b>BCBSM</b> – Required when loop 2300/CLM05-3 is 7 or 8 (Status Inquiry Claim), report a qualifier of F8 in REF01 and the Document Control Number (DCN) of the BCBSM original claim in REF02. <b>Medicare Advantage/Medicare Plus Blue</b> (including DME) – Use a claim frequency code 1 or 7. If a claim frequency code 7 is used please report an original claim DCN in the REF segment (Qualifier F8). <b>BCN and BCN Advantage</b> – Required when CLM05-3 is 7 or 8. If a claim frequency code 7 or 8 is submitted, the original claim reference number ICN/DCN (must start with an E, M, or 0 (zero) followed by 11 digits). See Overview Section of this document for additional information on reporting BCBSM and BCN Status Inquiry Claims. <b>MDCH (Medicaid)</b> – When loop 2300/CLM05-3 is 7 of 8, report a qualifier of F8 in REF01 and the 10 digit Claim Reference Number assigned by MDCH (Medicaid) to the last approved claim in REF02.	Original Claim Reference Number (ICN/DCN)
2300 and 2400	CR102	<b>Medicare</b> – Negative values are not valid for this element and could result in the claim being rejected.	Patient Weight
2300	CR106	<b>Medicare and Medicare DMERC</b> – Negative values are not valid for this element and could result in the claim being rejected.	Transport Distance

Loop	Segment/Element	Instruction	Industry/Element Name
2300	HI Segment Diagnosis Code	<p><b>All Payers</b> – Do not report decimal points in diagnosis codes. Diagnosis codes should always be reported in the highest specificity available. Use the diagnosis code pointer in loop 2400 to relate the diagnosis to specific service lines.</p> <p><b>BCBSM, Medicare Advantage/Medicare Plus Blue</b> (including DME), <b>BCN, BCN Advantage, and FEP</b> – Diagnosis codes will be validated for reported dates relating to the service. At this time, only one diagnosis code will be referenced per service line.</p> <p><b>Medicare</b> – Up to eight diagnosis codes can be sent per claim.</p> <p><b>Medicare DMERC</b> – Only the first four diagnosis codes will be considered for claim processing on Medicare DMERC claims.</p> <p><b>MDCH (Medicaid)</b> – At least one diagnosis code is required on every claim.</p> <p><b>Commercial</b> – Some payers may only recognize up to four diagnosis codes.</p>	Health Care Diagnosis Codes
2305	CR701-CR703 Home Health Segment	<b>BCBSM</b> – Although EDI will accept Home Health and Hospice claims in the Professional 837 format, for proper adjudication, submit Home Health and Hospice in the Institutional 837 rather than Professional 837.	Home Health Segment
2310A	NM104	<b>All Payers</b> – Required if NM102 equals 1. Must not be present if NM102 equals 2.	Referring Provider First Name
2310A	NM108, NM109	<p>When NM108=XX, then NM109 must contain the 10 digit numeric National Provider Identifier (NPI).</p> <p><b>BCBSM and FEP</b> – If only one iteration of this loop is being reported (Qualifier ‘DN’ Referring Provider), report the NPI of the referring/ordering physician in all cases when a patient was referred for services. This includes services ordered/referred by another physician or self-referral/no referral services. If the referring/ordering physician is not licensed in Michigan or the NPI is not known, repeat the NPI of the Billing provider from the 2010AA loop. If more than one iteration of this loop is being reported (Qualifier ‘DN’ Referring Provider and ‘P3’ Primary Care Provider), the ‘DN’ is used to report the actual provider referring services and the ‘P3’ is used to report the Primary Care physician. Can be reported in either loop 2310A or 2420F.</p> <p><b>BCBSM</b> – For PPO physician referrals, it is required in order to receive full payment on all out of panel referrals. If only one iteration of this loop is being reported (Qualifier ‘DN’ Referring Provider), report the NPI of the PPO Physician referring services. If more than one iteration of this loop is being reported (Qualifier ‘DN’ Referring Provider and ‘P3’ Primary Care Provider), the ‘DN’ is used to report the actual provider referring services and the ‘P3’ is used to report the original PPO out of network physicians NPI. If the referring/ordering physician is not licensed in Michigan or the NPI is not known, repeat the NPI of the Billing provider from the 2010AA loop. If the Billing NPI is used, this may impact adjudication. Can be reported in either loop 2310A or 2420F.</p>	Referring Provider ID
2310B	NM104	<b>All Payers</b> – Required if NM102 equals 1. Must not be present if NM102 equals 2.	Rendering Provider First Name
2310B	NM108, NM109	<b>All Payers</b> – When NM108 qualifier=XX then NM109 must contain the 10 digit numeric National Provider Identifier (NPI).	Rendering Provider ID

Loop	Segment/Element	Instruction	Industry/Element Name
2310B	PRV Segment	Required when adjudication is known to be impacted by the provider taxonomy (specialty) code and the billing/pay-to provider is not the rendering provider. Use the provider taxonomy code listing available for download from <a href="http://www.wpc-edi.com">www.wpc-edi.com</a> .  <b>BCBSM/FEP</b> – Chiropractic providers must report a valid taxonomy code on supplemental x-ray claims at the claim or service level when not reported at the billing provider level. Valid code values are: 111N00000X = Chiropractic 111N10900X = Internist 111NN0400X = Neurology 111NN1001X = Nutrition 111NX0100X = Occupational Medicine 111NX0800X = Orthopedic 111NR0200X = Radiology 111NS0005X = Sports Physician 111NT0100X = Thermography	Rendering Provider Specialty (Taxonomy) Code
2310C	N103	<b>BCBSM</b> – Required if net purchase amount is reported in loop 2300 (AMT with NE qualifier).	Purchased Service Provider Last Name
2310C	NM104	<b>All Payers</b> – Required if NM102 equals 1	Purchased Service Provider First Name
2310C	NM108, NM109	<b>All Payers</b> – When NM108 qualifier=XX then NM109 must contain the 10 digit numeric National Provider Identifier (NPI).	Purchased Service Provider ID
2310D	NM103	<b>BCBSM</b> – (Qualifier 77 and FA) Used to report the Facility Name for OPC and other applicable claims when services were performed in a facility. Do not report service/facility location when 2300 CLM5-1 is equal to 12 (home). <b>Medicare Advantage/Medicare Plus Blue</b> (including DME) <b>and Medicare</b> – (Qualifier FA) Report the Service Facility Name when the service is performed in a Health Professional Shortage Area (HPSA). Report the Laboratory Name (Qualifier LI) when a participating hospital-leased laboratory or independent laboratory (including services to a patient at home or in an institution) performs laboratory services.	Lab or Facility Name
2310D	NM104	<b>All Payers</b> – Must not be present if NM102 equals 2.	Service Facility First Name
2310D	NM108, NM109	<b>All Payers</b> – When NM108 qualifier=XX then NM109 must contain the 10 digit numeric National Provider Identifier (NPI).	Service Facility Primary ID
2310D	N301, N401-N403	<b>Medicare</b> – Whenever a lab or facility name and facility code is reported, the address must also be reported.	Facility Address
2310E	NM104	<b>All Payers</b> – Required if NM102 equals 1.	Supervising Provider First Name
2310E	NM108, NM109	<b>All Payers</b> – When NM108 qualifier=XX then NM109 must contain the 10 digit numeric National Provider Identifier (NPI).	Supervising Provider Primary ID
2320	SBR Segment Other Subscriber Information	<b>All Payers</b> – Required if other payers could potentially be involved in payment of this claim. SBR01 is used to identify the payment responsibility of the other payer. Repeat this loop for each other payer.	Other Subscriber Information Segment

Loop	Segment/Element	Instruction	Industry/Element Name
2320	SBR01	<p><b>All Payers</b> – Only one payer can be designated as the primary or the secondary payer (loops 2000B and 2320). All other payers reported should be designated as a tertiary payer. When submitting a secondary claim (loop 2000B, SBR01 = S) to the destination payer, there must be one 2320 loop present where SBR01 equals the value of P. When submitting a tertiary claim (loop 2000B, SBR01 = T) to the destination payer there must be two 2320 loop present where SBR01 equals the values of P and S.</p> <p><b>BCBSM and BCN</b> – Must be present on all secondary claims (loop 2000B, SBR01 = S). This includes BCBSM supplemental chiropractic x-ray claims.</p> <p><b>MDCH (Medicaid)</b> – If the patient has other insurance, report primary payer coverage with code P and any other insurance with codes S or T as appropriate.</p> <p><b>Commercial</b> – Cannot contain the same value as Loop 2000B, SBR01.</p>	Payer Responsibility Sequence Number Code
2320	SBR02	<p><b>All Payers</b> – Must be a valid code value. See implementation guide for a list of valid code values.</p>	Individual Relationship Code
2320	SBR03	<p><b>Medicare</b> – Report the group number or the FECA (Federal Employee Compensation Act) number pertaining to the other insurance coverage in Medicare Secondary Payer (MSP) situations. Otherwise, report the policy and/or group number of the other insured, if applicable.</p> <p><b>MDCH (Medicaid)</b> – Use the subscriber’s group number (assigned by the other payer), not the number that uniquely identifies the subscriber.</p> <p><b>Commercial</b> – Required for most commercial payers.</p>	Other Insured Group or Policy Number
2320	SBR04	<p><b>Commercial</b> – Required for most commercial payers.</p>	Other Insured Group Name
2320	SBR05, SBR09	<p><b>Medicare Advantage/Medicare Plus Blue, Medicare and MDCH (Medicaid)</b> – When reporting information pertaining to other payers, the Insurance Type Code and/or Claim Filing Indicator cannot be the same as reported for Medicare or Medicaid as the destination payer.</p>	Insurance Type Code Claim Filing Indicator
2320	CAS	<p><b>BCBSM, BCN, BCN Advantage and Medicare Advantage/Medicare Plus Blue</b> (including DME) – To ensure proper processing of secondary claims, all prior payer adjustments should be reported at the service level.</p>	Claim Level Adjustments
2320	AMT02 Qualifier D	<p><b>BCBSM, BCN and FEP</b> – Required when SBR01 in loop 2000B equals S.</p> <p><b>Medicare and Medicaid</b> – Required when SBR01 in loop 2000B equals S or T.</p> <p><b>BCBSM, BCN and FEP</b> – Required on all secondary (except BCBSM supplemental chiropractic x-ray claims) claims when a claim level approved or allowed amount is present and the entire amount is not applied to the patient’s deductible. Must equal the claim charge minus all prior payer adjustment amounts and be the accumulation of all service level equivalent amounts.</p> <p><b>Medicare and Medicare Advantage/Medicare Plus Blue</b> (including DME) – Must equal the sum of the equivalent service line paid amount (loop 2430 SVD02) if present.</p> <p><b>Medicare and Medicare DMERC</b> – Negative values are not valid for this element and could result in the claim being rejected.</p>	Payer Amount Paid
2320	AMT02 Qualifier AAE	<p><b>BCBSM and BCN</b> – Either an approved (Qualifier AAE) or allowed (Qualifier B6) amount must be present on all claims (except BCBSM supplemental chiropractic x-ray claims) when BCBSM is not the primary payer. Must not be greater than the claim charge and must equal the sum of all approved amounts reported at the service level. Zero is an acceptable value.</p> <p><b>Medicare and Medicare Advantage/Medicare Plus Blue</b> (including DME) – Must equal the sum of all equivalent service line approved amounts (loop 2400 AMT02) if present.</p>	Approved Amount

Loop	Segment/Element	Instruction	Industry/Element Name
2320	AMT02 Qualifier B6	<b>BCBSM, BCN and BCN Advantage</b> – Either an approved (Qualifier AAE) or allowed (Qualifier B6) amount must be present on all claims (except BCBSM supplemental chiropractic x-ray claims) when BCBSM is not the primary payer. Must not be greater than the claim charge and must equal the sum of all approved amounts reported at the service level. Zero is an acceptable value. <b>Medicare and Medicare DMERC</b> – Negative values are not valid for this element and could result in the claim being rejected.	Allowed Amount
2320	DMG02	<b>All Payers</b> – Required if 2330A/NM102 equals 1. <b>Medicare</b> – Enter the Medigap or other insured’s birth date. Must be less than or equal to the current date.	Other Insured Birth Date
2320	DMG03	<b>All Payers</b> – Required if 2330A/NM102 equals 1. <b>Medicare</b> – Enter the Medigap or other insured’s gender code.	Other Insured Gender Code
2320	OI04	<b>BCBSM</b> – Required when OI06 is present	Patient Signature Source Code
2320	MOA01	<b>BCBSM</b> – Used to designate the outpatient psychiatric rate for supplemental claims.	Percent
2330A	NM103-NM105	<b>All Payers</b> – NM104 is required if NM102 equals 1. Must not be present if NM102 equals 2. <b>BCBSM, BCN, BCN Advantage and Medicare Advantage/Medicare Plus Blue</b> (including DME) – Last and first name of other insured required on secondary claims. <b>Medicare</b> – Required if enrolled in a Medigap or other policy. <b>MDCH (Medicaid)</b> – Required if enrolled in a policy in addition to MDCH (Medicaid).	Other Insured Name
2330A	NM109 Qualifier MI	<b>Medicare</b> – When MDCH (Medicaid) is secondary to Medicare, enter the patient’s MDCH (Medicaid) number. Otherwise, enter the policy number of the Medigap or other insured, if applicable. <b>BCBSM, BCN, BCN Advantage Medicare Advantage/Medicare Plus Blue</b> (including DME), <b>FEP, Commercial and MDCH (Medicaid)</b> – Use the unique number assigned to the subscriber by the other payer indicated in loop 2330B.	Other Insured Identifier
2330A	N301, N302, N401, N402, N403	<b>Medicare</b> – Enter the mailing address of the insured when any other payers are known to be involved in paying this claim and the information is available.	Insured Mailing Address
2330A	REF01	Cannot equal SY when primary payer is Medicare.	Other Subscriber Secondary Identification
2330B	NM103	<b>BCBSM, BCN, BCN Advantage and Medicare Advantage/Medicare Plus Blue</b> (including DME) – Name of prior payer required on all secondary claims. <b>Medicare</b> – Report the name of the Medigap or other insured enrollee’s insurance.	Other Payer Last or Organization Name
2330B	NM104	<b>All Payers</b> – Must not be present if NM102 equals 2.	Other Payer First Name
2330B	NM109	<b>Medicare</b> – Report the Medigap insurer’s unique identifier provided by the local Medicare carrier. <b>MDCH (Medicaid)</b> – Use qualifier PI and enter the carrier code assigned by MDCH (Medicaid). See the MDCH web site for a listing of carrier codes.	Other Payer Primary ID
2330B	DTP Segment Qualifier 573	<b>MDCH (Medicaid)</b> – When 2000B/SBR01 equals S or T then either 2330B/DTP segment or 2430/SVD segment must be present.	Claim Adjudication Date
2330D through 2330H	REF Segments	<b>All Payers</b> – Provider information should only be reported when there is a requirement to report secondary provider IDs for the non-destination payer.	

Loop	Segment/Element	Instruction	Industry/Element Name
2400	SV101-1, SV101-2	<p><b>BCBSM and FEP</b> – For Home Infusion Therapy (HIT) claims, report appropriate procedure codes in this element and the National Drug Code (NDC) in LIN03 in loop 2410. HCPCS procedure code which will be validated for reported dates related to the service. When reporting a procedure code that is ‘not otherwise classified’ (NOC), include narrative in loop 2400 NTE03.</p> <p><b>BCBSM</b> – At this time BCBSM requires separate secondary claim submission for the following situations:</p> <ul style="list-style-type: none"> <li>• On supplemental claims, when there is a combination of services that were paid and denied by the primary payer.</li> <li>• Supplemental chiropractic x-ray services.</li> </ul> <p><b>Medicare Advantage/Medicare Plus Blue</b> (including DME) – must equal HC.</p> <p><b>All Payers</b> – If SV101-1 equals HC then SV101-2 must be 5 characters.</p>	Product/Service ID Qualifier
2400	SV101-3, SV101-4, SV101-5, SV101-6	<p><b>All Payers</b> – Modifiers will be validated for reported dates relating to the service and must be reported in sequence.</p> <p><b>BCBSM, BCN, BCN Advantage and FEP</b> – The professional 837 transaction set does not include the reporting of type of service codes. For proper claim adjudication of certain services, national modifiers should be reported. Some examples include services such as Durable Medical Equipment-DME (NU, BP, UE, BR/RR/LL), Technical Surgical Assistant-TSA (80, 81, 82), Professional or Technical Components (26, TC) and Ambulatory Surgical Centers (SG). OPC psychologist or social worker providers must report one of the modifiers below to indicate their level of education. Modifier AH = Psychologist = Level 2</p> <ul style="list-style-type: none"> <li>• Modifier AJ = Social Worker = Level 3</li> <li>• Modifier HO = Masters Degree = Level 3</li> </ul> <p>Valid values are: AH, and AJ.</p> <p><b>BCBSM, FEP and Medicare DMERC</b> – Only three modifiers will be used for processing.</p> <p><b>BCN and BCN Advantage</b> – Four modifiers will be used for processing.</p> <p><b>Medicare</b> – Medicare B will process using the first two reported modifiers.</p>	Modifiers
2400	SV102	<p><b>All Payers</b> – The sum of all service line charges must equal the claim level charge.</p> <p><b>Medicare, Medicare DMERC and Commercial</b> – Negative values are not valid for this element.</p>	Line Item Charge Amount
2400	SV104	<p><b>BCBSM</b> – Cannot exceed 999 for non-HIT services. Must be present when a HIT Per Diem procedure is reported and on other HIT services to report the quantity of the drug being infused. For HIT drug services, report a quantity up to a maximum of 9999.9.</p> <p><b>BCBSM and FEP</b> – For proper adjudication on anesthesia services, always report qualifier MJ and the anesthesia quantity in minutes.</p> <p><b>BCN and BCN Advantage</b> – For proper adjudication on anesthesia services, report qualifier UN and the anesthesia quantity in units until further notice. For other services, do not report units unless the description of the procedure code references quantity.</p> <p><b>MDCH (Medicaid)</b> – Must be greater than zero.</p> <p><b>Medicare and Medicare DMERC</b> – Negative values are not valid for this element and could result in the claim being rejected. Service unit counts (units or minutes) cannot exceed 999.9.</p>	Service Unit Count
2400	SV105	<p><b>All Payers</b> – If present must be a valid code.</p>	Facility Type Code

Loop	Segment/Element	Instruction	Industry/Element Name
2400	SV107	<b>All Payers</b> – At least one diagnosis pointer is required. All reported diagnosis pointers must relate to a diagnosis reported in 2300/HI segment. Pointers should be reported in declining level of importance to the service line. <b>BCBSM</b> – At this time only one diagnosis code will be referenced per service.	Diagnosis Code
2400	PWK and NTE Segments	<b>BCBSM, BCN, BCN Advantage, FEP and MDCH (Medicaid)</b> –The NTE segment should be used when, in the opinion of the provider, the information is needed to substantiate the medical treatment and is not supported elsewhere within the claim data set. The NTE segment is equivalent to what providers previously referred to as “Notepad”. The NTE segment in loops 2300 or 2400 should be used to report supporting documentation for individual consideration (IC) and only in loop 2400 Not Otherwise Classified (NOC) procedures. When using the NTE segment, report qualifier ADD in NTE01. <b>BCBSM, BCN, BCN Advantage, FEP, Medicare Advantage/Medicare Plus Blue, Medicare, Medicare DMERC and Commercial</b> – Any data submitted in the PWK (Paperwork) segment may not be considered for processing. <b>Medicare</b> – See Overview Section of this document for guidelines for submission of secondary claims. <b>Commercial</b> – Use the NTE segment in loop 2400 when the procedure code is “Not otherwise classified”.	Paperwork and Billing Notes (Claim and Service Level)
2400	CR102	<b>Medicare</b> – Negative values are not valid for this element and could result in the claim being rejected.	Patient Weight
2400	CR106	<b>Medicare and Medicare DMERC</b> – Negative values are not valid for this element and could result in the claim being rejected.	Transport Distance
2400	CR301-CR303	<b>BCBSM</b> – Required on all Blue Shield Durable Medical Equipment (DME) claims.	DME Certification Segment
2400	CR303	<b>BCBSM</b> – If more than 12 months are reported, claim will be manually reviewed for adjudication. Report 99 to indicate lifetime duration of need.	Duration of Need
2400	CR502	<b>BCBSM</b> – If more than 12 months are reported, claim will be manually reviewed for adjudication. Report 99 for lifetime duration of need.	Duration of Need, Oxygen
2400	CR510-511	<b>BCBSM</b> – When reporting CR5 segment, CR510 or CR511 must be present.	Quantity
2400	DTP03 Qualifier 472	<b>All Payers</b> – When a date range is reported then the “to” date must be greater than or equal to the reported service date. <b>BCBSM</b> – Report applicable service dates. <b>BCN and BCN Advantage</b> – For maternity claims, the “from” date must be the same as the “to” date and the number of visits must be reported in the units field (Loop 2400, SV104). <b>MDCH (Medicaid)</b> – Date of service cannot be more than two years old. <b>Commercial</b> – When an admission date 2300/DTP03 (Qualifier = 435) is reported it must be prior or equal to the “from” date of service of all service lines.	Service Date
2400	DTP03 Qualifier 431	<b>Commercial</b> – Only use when different from the date entered at the claim level (Loop 2300).	Onset of Current Symptom/Illness Date
2400	DTP03 Qualifier 438	<b>Commercial</b> – Only use when different from the date entered at the claim level (Loop 2300).	Similar Illness/Symptom Onset
2400	DTP03 Qualifier 607	<b>BCBSM</b> – Required when a Durable Medical Equipment certification (CMN) is present in 2400/CR301 and equal to R or S.	Certificate Revision Date

Loop	Segment/Element	Instruction	Industry/Element Name
2400	CN101, CN102	<b>Medicare</b> – On Medicare Secondary Payer (MSP) claims, report a value of 09 in CN101 and the claim total Obligated to Accept as Payment in Full (OTAF) amount in CN102. Should be used when service level OTAF is available. Otherwise, report at claim level when applicable. Refer to COB section for specific reporting instructions.	Contract Type Code and Contract Amount
2400	REF02 Qualifier EW	<b>Medicare</b> – If the supplier is a certified mammography screening center, enter the FDA approved certification number. When more than one supplier is used, a separate claim should be used to bill for each supplier.	Mammography Certification Number
2400	AMT02 Qualifier AAE	<b>BCBSM, BCN and BCN Advantage</b> – Report approved amount (Qualifier AAE) on all claims when BCBSM/BCN is not the primary payer (except BCBSM supplemental chiropractic x-ray services). Zero is an acceptable value. Must not be greater than the service charge and sum of all service line approved amounts must equal the approved or allowed amount reported at the claim level. Required when the service level paid amount is greater than zero. Must be greater than the service level paid amount. <b>Medicare</b> – If reported, the sum of these fields for all service lines must equal the equivalent approved amount in loop 2320 AMT02.	Approved Amount
2400	NTE Segment	<b>BCBSM and FEP</b> – Used to submit narrative description of Not Otherwise Classified (NOC) procedures or to provide additional supporting information. <b>Medicare</b> – Refer to section indicating guidelines for submission of secondary claims for specific reporting instructions. <b>Commercial</b> – If submitted, will override the NTE segment at the claim level (Loop 2300). Required when procedure code is “Not Otherwise Classified”.	Service Line Notes
2400	PS101	<b>Medicare</b> – Required on service lines involving a purchased service/test. Enter the state specific provider number of the entity performing the purchased test.	Purchased Service Provider ID
2400	PS102	<b>Medicare and Medicare DMERC</b> – Negative values are not valid for this element and could result in the claim being rejected.	Purchased Service Charge Amount
2410	LIN03	<b>BCBSM</b> – Report the National Drug Code (NDC) for Home Infusion Therapy (HIT) claims (do not use dashes or spaces). <b>BCBSM and Medicaid</b> – Only the first repeat will be processed. Any additional repeats will be ignored	Product/Service ID
2420A	All	<b>All Payers – Not required if the same as what was reported in 2010AA or 2310B.</b>	Rendering Provider
2420A	NM1 segment	<b>BCN</b> – Cannot be different than the rendering provider in loop 2310B. <b>Commercial</b> – Required if different than the rendering provider in loop 2310B.	Rendering Provider Name and ID
2420A	NM104	<b>All Payers</b> – Required if NM102 equals 1. Must not be present if NM102 equals 2.	Rendering Provider First Name
2420A	NM108, NM109	<b>All Payers</b> – When NM108 qualifier=XX then NM109 must contain the 10 digit numeric National Provider Identifier (NPI).	Rendering Provider Primary ID

Loop	Segment/Element	Instruction	Industry/Element Name
2420A	PRV segment	Required when adjudication is known to be impacted by the provider taxonomy (specialty) code and the billing/pay-to provider is not the rendering provider and this code is different than reported at the claim level. Use the provider taxonomy code listing available for download from <a href="http://www.wpc-edi.com">www.wpc-edi.com</a> . <b>BCBSM/FEP</b> – Chiropractic providers must report a valid taxonomy code on supplemental x-ray claims at the claim or service level when not reported at the billing provider level. Valid code values are: 111N00000X = Chiropractic 111N10900X = Internist 111NN0400X = Neurology 111NN1001X = Nutrition 111NX0100X = Occupational Medicine 111NX0800X = Orthopedic 111NR0200X = Radiology 111NS0005X = Sports Physician 111NT0100X = Thermography	Rendering Provider Specialty Information
2420B	All	<b>Not required if the same as what was reported in 2310C.</b>	Purchased Service Provider
2420B	NM103, NM104	<b>All Payers</b> – Must not be present.	Purchased Service Provider Last Name or Organization Name and First Name
2420B	NM108, NM109	<b>All Payers</b> – When NM108 qualifier=XX then NM109 must contain the 10 digit numeric National Provider Identifier (NPI).	Purchased Service Provider Primary ID
2420C	All	<b>Not required if the same as what was reported in 2310D.</b>	Service Facility Location.
2420C	NM103	<b>Not required if the same as what was reported in loop 2310D.</b> <b>BCBSM</b> – Do not report service/facility location when 2300 CLM5-3 is equal to 12 (home). <b>Medicare Advantage/Medicare Plus Blue</b> (including DME) <b>and Medicare</b> – (Qualifier FA) Report the Service Facility Name when the service is performed in a Health Professional Shortage Area (HPSA). Report the Laboratory Name (Qualifier LI) when a participating hospital-leased laboratory or independent laboratory (including services to a patient at home or in an institution) performs laboratory services. Do not report if service was performed in the patient’s home. <b>Commercial</b> – (Qualifier FA) Report the entire Service Facility Name.	Lab or Facility Name
2420C	NM104	<b>All Payers</b> – Must not be present if NM102 equals 2.	Service Facility First Name
2420C	NM108, NM109	<b>All Payers</b> – When NM108 qualifier=XX then NM109 must contain the 10 digit numeric National Provider Identifier (NPI).	Service Facility Primary ID
2420D	All	<b>Not required if the same as what was reported in 2310E.</b>	Supervising Provider
2420D	NM104	<b>All Payers</b> – Required if NM102 equals 1.	Supervising Provider First Name
2420D	NM108, NM109	<b>All Payers</b> – When NM108 qualifier=XX then NM109 must contain the 10 digit numeric National Provider Identifier (NPI).	Supervising Provider Primary ID
2420E	All	<b>Not required if the same as what was reported in 2310A.</b>	Ordering Provider
2420E	NM104	<b>All Payers</b> – Required if NM102 equals 1.	Ordering Provider First Name

Loop	Segment/Element	Instruction	Industry/Element Name
2420E	NM108, NM109	<b>All Payers</b> – When NM108 qualifier=XX then NM109 must contain the 10 digit numeric National Provider Identifier (NPI).	Ordering Provider Primary ID
2420F	All	<b>All Payers</b> – Not required if the same as what was reported in 2310A.	Referring Provider
2420F	NM104	<b>All Payers</b> – Required if NM102 equals 1. Must not be present if NM102 equals 2.	Referring Provider First Name
2420F	NM108, NM109	When NM108=XX then NM109 must contain the 10 digit numeric National Provider Identifier (NPI). When reported in loop 2420F, this overrides the referring provider reported in loop 2310A for this service only.  <b>BCBSM</b> – If only one iteration of this loop is being reported (Qualifier ‘DN’ (Referring Provider), is reported in NM101 of this segment), report XX in NM108 and the NPI of the referring physician in all cases when a patient was referred for services. This includes services referred by another physician or self-referral/no referral services. If the referring physician is not licensed in Michigan or the NPI is not known, repeat the NPI of the Billing Provider from the 2010AA loop.  In order to avoid patient sanctions for services that were performed by an out-of-network provider, report a second iteration of this loop (Qualifier P3 (Primary Care Provider) is reported in NM101 of this segment). This is used to report the initial PPO network provider.	Referring Provider Primary ID
2430	SVD Line Adjudication Segment	<b>MDCH (Medicaid)</b> – MDCH (Medicaid) expects this loop for each payer identified in loop 2320, except when that payer has adjudicated the claim at the claim level. Required when 2000B/SBR01 equals S or T and 2330B/DTP segment with 573 Qualifier is not present.	Line Adjudication Information
2430	SVD01	<b>BCBSM, BCN, BCN Advantage FEP, MDCH (Medicaid) and Medicare, Medicare Advantage/Medicare Plus Blue</b> (including DME) – Must equal value reported in one of ten other payer loops (2330B/NM109).	Other Payer Primary ID
2430	SVD02	<b>All Payers</b> – Will be verified to determine if it is a valid code for the service related dates of service. <b>BCBSM, BCN and BCN Advantage</b> – Required on all secondary claims when a service level approved amount is present and the entire amount is not applied to the patient’s deductible. Cannot equal provider’s service charge. Accumulation of all service level paid amounts must equal the claim level prior payer paid amount. Must equal service charge minus all prior payer service level adjustment amounts. When greater than zero, an approved amount must be reported. Must be less than the service level approved amount.	Service Line Paid Amount
2430	CAS segment	<b>BCBSM, BCN and BCN Advantage</b> – When reporting an adjustment for the deductible amount from the prior payer it must be less than or equal to the approved amount.	Claims Adjustment Segment
2430	CAS02	<b>BCBSM, BCN, BCN Advantage, FEP, and Medicare Advantage/Medicare Plus Blue</b> (including DME) – Must contain the applicable Claim Adjustment Reason Code to identify the reason that the primary payer adjusted the charge submitted. Do not report at the claim level.	Claim Adjustment Reason Code
2430	DTP	<b>BCBSM and BCN</b> – Required on all secondary claims. Report the date the primary carrier paid the claim.	
2440	LQ	<b>Medicare, Medicare DMERC and Medicare Advantage/Medicare Plus Blue</b> (including DME)	Form Identification
2440	FRM	<b>Medicare, Medicare DMERC and Medicare Advantage/Medicare Plus Blue</b> (including DME)	Supporting Documentation

## Data Clarifications for the Professional 835 (004010X098A1) Transaction Set

Loop	Segment/Element	Instruction	Industry/Element Name
	BPR01	<b>BCBSM, Medicare Advantage/Medicare Plus Blue</b> – H will be returned for nonpayment and I will be returned for payment/remittance information.	Transaction Handling Code
	BPR02	This will balance to the total of all claim payments minus any provider level adjustments.	total Actual Provider Payment Amount
	BPR04	<b>BCBSM, Medicare Advantage/Medicare Plus Blue</b> – CHK will be returned for payment/remittance information. NON will be returned for nonpayment.	Payment Method Code
	TRN02	The check number that was issued to the provider or EFT transfer number. <b>BCBSM Medicare Advantage/Medicare Plus Blue</b> – For remittance files containing all non-paid claims or a provider withhold adjustment, a unique generated check number will be returned.	Trace Number
	TRN03	<b>BCBSM, Medicare Advantage/Medicare Plus Blue</b> – 1+382069753 <b>MESSA</b> – 1+381641634 <b>BCN and BCN Advantage</b> – 1+382359234	Payer Identifier
	REF02	<b>BCN FACETS</b> – 382069753	Receiver Identification
1000A	N102	<b>BCBSM, Medicare Advantage/Medicare Plus Blue</b> – BCBSM will be returned. <b>NASCO</b> – BCBSM will be returned. <b>MESSA</b> – MESSA will be returned. <b>BCN</b> – Blue Care Network or Michigan will be returned.	Payer Name
1000A	N301	<b>BCBSM, Medicare Advantage/Medicare Plus Blue and NASCO</b> – 600 E. Lafayette will be returned. <b>MESSA</b> – P.O. Box 2560, 1475 Kendale Blvd. will be returned. <b>BCN and BCN Advantage</b> – 25925 Telegraph Road will be returned.	Payer Address
1000A	N401	<b>BCBSM, Medicare Advantage/Medicare Plus Blue and NASCO</b> – Detroit will be returned. <b>MESSA</b> – East Lansing will be returned. <b>BCN and BCN Advantage</b> – Southfield will be returned.	Payer City
1000A	N402	<b>BCBSM, NASCO, MESSA and BCN FACETS</b> – MI will be returned.	Payer State
1000A	N403	<b>BCBSM, Medicare Advantage/ Medicare Plus Blue and NASCO</b> – 48226 will be returned. <b>MESSA</b> – 48823 will be returned. <b>BCN and BCN Advantage</b> – 48034 will be returned.	Payer Zip Code
1000A	REF01, REF02	<b>BCBSM</b> – REF01 will contain 2U and REF02 will contain 00710. <b>Medicare Advantage/Medicare Plus Blue</b> – REF01 will contain 2U and REF02 will contain 210. <b>NASCO</b> – REF01 will contain 2U and REF02 will contain 710. <b>MESSA</b> – Not used. <b>BCN and BCN Advantage</b> – Not used.	Additional Payer ID
1000A	PER03, PER04	<b>BCN</b> – PER03 will contain TE and PER04 will contain 2483547450. This is the telephone number for BCN provider inquiry.	Payer Contact Communication Number
1000B	N103	<b>BCN and BCN Advantage</b> – If NPI is enrolled with Blue Care Network qualifier XX will be returned.	Identification Code Qualifier
1000B	N104	<b>BCN and BCN Advantage</b> – If NPI is enrolled with Blue Care Network the National Provider Identifier (NPI) will be returned.	Payee Identification Code

Loop	Segment/Element	Instruction	Industry/Element Name
1000B	N301, N302	<b>BCBSM, Medicare Advantage/Medicare Plus Blue</b> – May contain payee address information in N301. <b>NASCO</b> – Not used. <b>MESSA</b> – Not used. <b>BCN and BCN Advantage</b> – N301 and N302 will contain payee address information.	Payee Address
1000B	N401-N403	<b>BCBSM, Medicare Advantage/Medicare Plus Blue, BCN and BCN Advantage</b> – will be returned. <b>MESSA and NASCO</b> – Not used.	Payee City, State and Zip Code
1000B	REF01, REF02	<b>BCBSM and MESSA</b> – REF01 will contain PQ and REF02 will contain the BCBSM provider code of the payee. <b>Medicare Advantage/Medicare Plus Blue</b> – REF01 will contain PQ and REF02 will contain the Medicare provider code. <b>NASCO</b> – REF02 will contain PQ and REF02 will contain 7102000 followed by the BCBSM provider code of the payee. <b>BCN and BCN Advantage</b> – From 07/01/05 through 09/30/05, in most cases, REF01 will contain PQ and REF02 will contain the BCN Bill Pin of the payee. An additional REF segment will be present which will include the BCBSM provider number (REF01 will contain a value of 1B). During the transition period, if only one of these two identifiers is available, it will be returned in the REF02 and REF01 will contain a value of PQ. Effective 10/01/05, REF01 will contain PQ and REF02 will contain the BCBSM provider number.	Additional Payee Identifier
2100	CLP01	<b>BCBSM, Medicare Advantage/Medicare Plus Blue, NASCO, MESSA, BCN and BCN Advantage</b> – If available, the provider-assigned patient control number will be returned. When not available, a value of 0 will be returned.	Patient Control Number
2100	CLP02	<b>BCBSM, NASCO, MESSA, BCN and BCN Advantage</b> – Code values of 1, 2, 4 or 22 will be returned. When a claim is transferred for further consideration of payment then applicable codes of 19, 20 or 21 will be returned. <b>Medicare Advantage/Medicare Plus Blue</b> – Code values of 1, 2, 3, 4 or 22 will be returned.	Claim Status Code
2100	CLP06	<b>BCBSM and MESSA</b> – Code values of 12 (par) or 15 (non-par) will be returned. <b>Medicare Advantage/Medicare Plus Blue</b> – Code values of 12 or 15 (Indemnity) will be returned. <b>NASCO</b> – Code values of HM (HMO), 12 (PPO), 13 (POS) or 15 (Indemnity) will be returned. <b>BCN and BCN Advantage</b> – HM will be returned.	Claim Filing Indicator Code
2100	CAS Segment	<b>BCBSM</b> – BCBSM Professional 835 adjustments are typically seen at a service level, if applicable, the Personal Savings Account (PSA)/Health Savings Account (HSA) will be returned at the claim level for out of state Blue Plan members. <b>Medicare Advantage/Medicare Plus Blue, NASCO, MESSA and BCN</b> – Adjustments will be returned at the service level only and will not be returned in the CAS segment of the 2100 loop.	Claim Adjustment (Claim Level)
2100	NM103	<b>BCBSM</b> – Some names may be truncated to five positions.	Patient Last Name
2100	NM108, NM109	<b>BCBSM, Medicare Advantage/Medicare Plus Blue, NASCO, MESSA and BCN</b> – NM108 will contain MI and the patient contract number will be returned.	Patient Contract Number
2100	NM1 Segment	<b>BCBSM, Medicare Plus Blue/Medicare Advantage, NASCO, MESSA and BCN</b> – This information will be returned when available if applicable.	Corrected Patient/Insured Name

Loop	Segment/Element	Instruction	Industry/Element Name
2100	NM1 Segment	<b>BCBSM</b> – Not used. <b>NASCO</b> – When present, NM108 will contain FI and NM109 will contain the Rendering Provider’s Federal Tax ID Number. <b>BCN and BCN Advantage</b> – When present, NM108 will contain FI, BS or SI and NM109 will contain the assigned number.	Service Provider Name/ID
2100	NM101	<b>BCBSM</b> – Qualifier TT will be reported when there is another payer (e.g., Master Medical, MESSA, Michigan Conference of Teamsters Welfare Fund or Blue Cross Blue Shield of Michigan) for further consideration of payment.	Crossover Carrier Name
2100	NM1 Segment	<b>BCBSM, NASCO, MESSA, BCN and BCN Advantage</b> – Returned if applicable.	Corrected Priority Payer Name
2100	REF01	<b>BCBSM, NASCO and MESSA</b> – 1L will be returned. <b>Medicare Advantage/Medicare Plus Blue</b> – CE will be returned. <b>BCN and BCN Advantage</b> – 1L, SY, A6, BB, or EA will be returned.	Other Claim Related ID
2100	DTM01	<b>BCBSM, Medicare Advantage/Medicare Plus Blue, MESSA and BCN</b> – DTM01 will contain 050. <b>NASCO</b> – DTM will contain 050, 232 and/or 233.	Claim Date Qualifier
2100	AMT01	<b>NASCO, BCN and BCN Advantage</b> – AMT01 will contain AU when applicable.	Claim Supplemental Amount Qualifier Code
2100	SVC01-1	<b>BCBSM, NASCO, MESSA, BCN and BCN Advantage</b> – HC will be returned.	Product or Service ID Qualifier Code
2110	SVC06-1	<b>BCBSM, NASCO, MESSA, BCN and BCN Advantage</b> – HC will be returned.	HCPCS Code (qualifier)
2110	SVC07	<b>BCBSM</b> – A quantity will be returned on pay-subscriber remittances.	Original Units of Service Count
2110	CAS Segment	<b>BCBSM, Medicare Advantage/Medicare Plus Blue, NASCO, MESSA, BCN and BCN Advantage</b> – Adjustments that are applicable to the service level will be returned. .	Service Adjustment (Service Level)
2110	REF01	<b>BCBSM, NASCO, MESSA and BCN</b> – REF01 will contain 6R and REF02 will contain the provider control number.	Line item control number
2110	REF01	<b>BCBSM and MESSA</b> – REF01 will contain 1B and REF02 will contain the Blue Shield provider ID number.	Rendering Provider ID
2110	AMT01	<b>BCBSM, Medicare Advantage/Medicare Plus Blue, NASCO, BCN and BCN Advantage</b> – AMT01 will contain B6 when applicable.	Service Supplemental Amount
2110	LQ01, LQ02	<b>BCBSM, Medicare Advantage/Medicare Plus Blue, MESSA, BCN and BCN Advantage</b> – LQ01 will contain HE and LQ02 will contain the Claim Payment Remark Code when applicable.	Claim Payment Remark Code
	PLB Segment	<b>BCBSM, Medicare Advantage/Medicare Plus Blue, NASCO, MESSA, BCN and BCN Advantage</b> – Used when applicable for provider withholds or interest payments.	Provider Level Adjustment

## **General EDI Terminology**

**Addenda** – Refers to a version of the HIPAA mandated transaction sets which corrects identified implementation issues noted in the original implementation guides.

**ANSI X12 835 v4010** – HIPAA standardized ANSI X12 transaction format for the claims remittance data.

**ANSI X12 837 v4010** – HIPAA standardized ANSI X12 transaction format for the claims submission data. All lines of business will use this transaction with the exception for retail pharmacy.

**BlueExchange** – A Blue Cross Blue Shield Association process through which non-claim HIPAA transactions for members from all other Blue Cross and/or Blue Shield plans can be accepted by a local host plan and routed to the home plan for processing. It also allows for receipt of 835 transactions for crossover remittances from other Blue Cross Blue Shield plans.

**Data Segment** – Corresponds to a *record* in data processing terminology. Consists of logically related data elements in a defined sequence (defined by X12). Each segment begins with a segment identifier, which is not a data element and one or more related data elements, which are preceded by a data element separator. Each segment ends with a segment terminator.

**Data Element** – Corresponds to a *field* in data processing terminology. Each data element is an assigned unique reference number. Each element has a name, description, type, minimum length and maximum length. The length of an element is the number of character positions used, except as noted for numeric, decimal and binary elements. Data element types are:

Nn	Numeric (with an assumed number of decimal positions)
R	Decimal Real Number (including decimal or negative sign)
ID	Identifier
AN	Alphanumeric string
DT	Date
TM	Time

**Delimiter** – A character used to separate two data elements (or sub-elements) or to end a segment. They are specified in the interchange header segment (ISA). Once specified in the ISA, they should not be used in the data elsewhere other than as a separator or terminator.

**EDI** – An acronym for Electronic Data Interchange.

**Electronic Data Interchange** – the application-to-application transfer of key business information transacted in a standard format using a computer-to-computer communications link. There are typically 6 components used in order to do EDI. They are: an EDI file, a trading partner, an application file/form, translator (mapper), communications and value added network or value-added service provider.

**CMS** – An acronym for Centers for Medicare and Medicaid Services.

**Implementation guides** – Documents that provide standardized data requirements and content as the specifications for consistent implementation of a standard transaction set. HIPAA implementation guides are published by the Washington Publishing Company on their web site: [www.wpc-edi.com](http://www.wpc-edi.com).

**Interface** – The point at which two systems connect to pass data.

**Loops** – Loops are groups of semantically related segments. Data segment loops may be unbounded or bounded.

**Routing** – Separation of data based on specific criteria for subsequent transfer to an internal or external system.

**Trading partners** – Entities that exchange electronic data files. Agreements are sometimes made between the partners to define the parameters of the data exchange and simplify the implementation process.

**Translation Software** – Commercial computer software that with input instructions converts a standard format to an application format or an application format to a standard format. Most translation software products also compliance check standard format files and automatically create interchange/functional acknowledgements to identify receipt and translation status of a file. Some products also offer translation capability from any format to any format.

**X12 Transaction Set** – A transaction set is considered one business document which is composed of a transaction set header control segment, one or more data segments, and a transaction set trailer control segment. For example, one 837-transaction set is equivalent to one claim file.

**X12N** – An Accredited Standards Committee (ASC) commissioned by the American National Standards Institute (ANSI) to develop standards for Electronic Data Interchange (EDI). While X12 indicates EDI, the N identifies the Insurance Subcommittee that is responsible for developing EDI standards for the insurance industry. There is a special health care task group within this subcommittee responsible for the development of health care insurance transactions.